

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First MOLLIE Middle NACHSIN Last NACHSIN		2a. DATE OF DEATH Month March Day 15 Year 1968		2b. HOUR 12:45
3. SEX Female	4. RACE White	5. DATE OF BIRTH 23 1911 December 23, 1911	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson 21204	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY BALTO	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1604 Melbourne Rd. 21222
14. FATHER'S NAME First DAVID Middle MELTZER Last		15. MOTHER'S MAIDEN NAME First ROSE Middle ZUTOMER Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT 4710 BROAD ST. PHILA RAPHAEL-SACKS MEM. CHAPEL. PA.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) uncontrollable post-operative bleeding. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201				
19a. DATE OF OPERATION 3/14/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary insufficiency; Arteriosclerotic Heart Dis.	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that 4 (this hospital) attended the deceased from March 1, 1968 , to March 15, 1968 , that 4 (we) lost saw the deceased alive on March 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE F. Malek, M.D.	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED March 15, 1968		
22d. PHYSICIAN'S NAME (Type) F. Malek MD.	22e. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL-BURIAL 3-17-68	23b. DATE 3-17-68	23c. NAME OF CEMETERY OR CREMATORY MONTEFIORE	23d. LOCATION (City or Town) (County) (State) PHILADELPHIA, PA.	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN	ADDRESS ROAD	25a. REC'D BY REGISTRAR MAK 19 1968	25b. REGISTRAR'S SIGNATURE [Signature]	

THE UNIVERSITY OF CHICAGO



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Emily			First Emily			Middle M.			Last Neff		
2a. DATE OF DEATH Month 3 Day 6 Year 68			2b. HOUR 12:50 A M								
3. SEX female			4. RACE white			5. DATE OF BIRTH March 5, 1887			6. AGE (In years last birthday) 80 YRS.		
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? U. S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Cato'sville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 1613 Harden Ct.		
14. FATHER'S NAME Charles B. Pugh			First Charles			Middle B.			Last Pugh		
15. MOTHER'S MAIDEN NAME Mary R. Dawson			First Mary			Middle R.			Last Dawson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 215-22-0023			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 486x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 413x										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from Oct. 26, 1967 , to March 6, 1968 , that (I) was last saw the deceased alive on March 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Sherwood Wilson, M.D.						DEGREE MD			22c. DATE SIGNED 3/6/68		
22d. PHYSICIAN'S NAME (Type) Sherwood, Wilson, M.D.						22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3 7 68			23c. NAME OF CEMETERY OR CREMATORY Glen Haven			23d. LOCATION (City or Town) (County) (State) Glen Burnie, A.A. Co. Md		
24. FUNERAL DIRECTOR Mc Cully						ADDRESS 130 E. Fort Ave			25a. REC'D BY REGISTRAR MAR 7 1968		
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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VR 415 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First ALMA Middle ROSEMAE Last NORRIS						2a. DATE OF DEATH Month March Day 24, 1968 Year			2b. HOUR P 11:35 M		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH January 31, 1941		6. AGE (In years last birthday) 27 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Towson 21204			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) State Hospital			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Marriottsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 94, Driver's Rd. 21104		
14. FATHER'S NAME First Middle Last Charles Franklin Randall				15. MOTHER'S MAIDEN NAME First Middle Last Alma Louise Lewis Randall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If you give war or dates of service) 217-38-5212		17. INFORMANT Address MR. OWEN Norris SYkesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Typhoid fever DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 0402											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from March 16, 1968, to March 24, 1968, that (X) (we) last saw the deceased alive on March 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Reynaldo Orjuela-Gomez, M.D.						22c. DATE SIGNED March 25, 1968					
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-28-68		23c. NAME OF CEMETERY OR CREMATORY St Lukes Cemetery		23d. LOCATION (City or Town) (County) (State) SYkesville Md.					
24. FUNERAL DIRECTOR Harry W. Haight						ADDRESS SYkesville, Md.		25a. REC'D BY REGISTRAR APR 1 - 1968		25b. REGISTRAR'S SIGNATURE James Judge	

MEDICAL CERTIFICATION

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03793

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03776

1. DECEASED NAME (Type or print) BERTHA MAY Noertner			2a. DATE OF DEATH Month 3 Day 11 Year 68			2b. HOUR 6:20 PM	
3. SEX Female		4. RACE Can		5. DATE OF BIRTH 10-27-83		6. AGE (In years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) Ramsey, Ill		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 826 Fresham Ave							
14. FATHER'S NAME First John W Middle GRAY Last GRAY			15. MOTHER'S MAIDEN NAME First LEATON Middle MARY J Last BUCKMASTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 215-54-4716		17. INFORMANT PT'S CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4270 Circulatory failure DUE TO, OR AS A CONSEQUENCE OF (b) 4341 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) 4341 Congestive heart failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4341							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 28-9, 1968 to 3-10, 1968 , that (I) (we) last saw the deceased alive on 3-10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. de Castro		DEGREE MA. JOSEFINA A. DE CASTRO		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-10-68	
22d. PHYSICIAN'S NAME (Type) MA. JOSEFINA A. DE CASTRO		22e. ADDRESS G B M C					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-13-1968		23c. NAME OF CEMETERY OR CREMATORY RAMSEY		23d. LOCATION (City or Town) (County) (State) RAMSEY	
24. FUNERAL DIRECTOR WM COOK-13 ROCKS TOWSON, TOWSON, MD				25a. REC'D BY REGISTRAR DATE MAR 12 1968		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

MEDICAL CERTIFICATION

22-11-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP -

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>WILLIAM J. NOWLAN</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>27</i> Year <i>1968</i>			2b. HOUR <i>6:25 A.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>Cau.</i>		5. DATE OF BIRTH <i>July 7, 1900</i>		6. AGE (In years last birthday) <i>67</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Canada</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>			
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shady Nook Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Custodian</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>College</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Jacksonville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Jarrettsville Pike</i>	
14. FATHER'S NAME First <i>Thomas</i> Middle <i>Nowlan</i> Last <i>Nowlan</i>			15. MOTHER'S MAIDEN NAME First <i>?</i> Middle <i>?</i> Last <i>?</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes, no or unknown</i>		16b. SOCIAL SECURITY NO. <i>19-28-68</i>		17. INFORMANT <i>Family Records</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of lung</i> <i>162.1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>163 X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>March 25, 1968</i> , to <i>March 27, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 25, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John A. Nesbitt, Jr.</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-27-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>JOHN A. NESBITT, JR.</i>		22e. ADDRESS <i>1009 Federal Rd, Baltimore Md 21228</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Mar. 30, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204				25a. REC'D BY REGISTRAR DATE <i>APR 1, 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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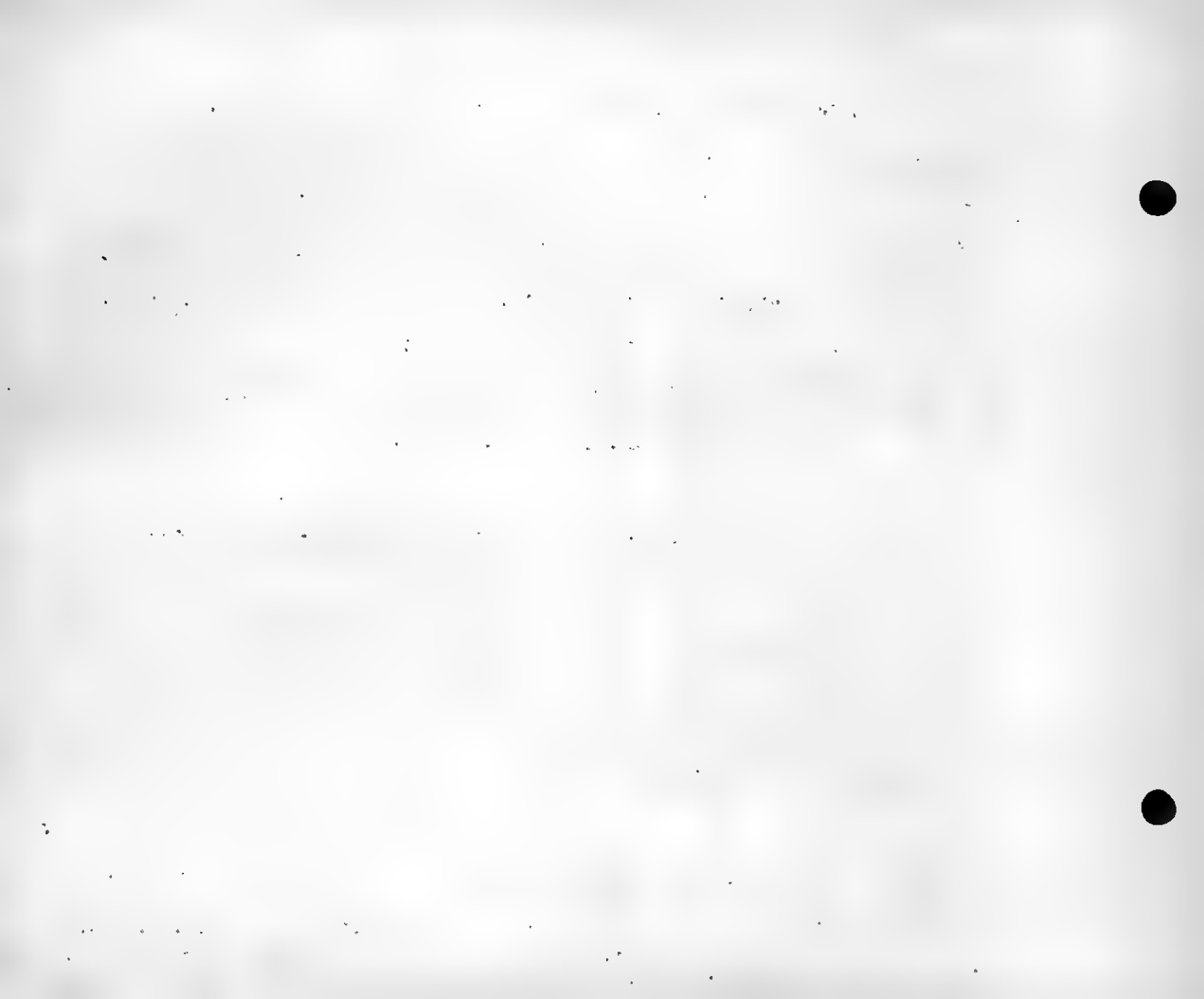


CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print) <u>Alexandrina Susanna Onderdonk</u>			2a. DATE OF DEATH 3 Month 31 Day 68 Year			2b. HOUR 10 A M				
3. SEX <u>Female</u>		4. RACE <u>Cau</u>		5. DATE OF BIRTH <u>6-7-82</u>		6. AGE (In years last birthday) <u>85</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <u>Balt. Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md				
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>G B M C</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>None</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				
13a. US. JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>BALTO. RIDERWOOD</u>		13c. CITY OR TOWN <u>RIDERWOOD</u>		13d. INSIDE CITY LIM 757 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Joppe Roan and Bellona Ave</u>		
14. FATHER'S NAME First Middle Last <u>Philip A. Barton</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>A N N A Oliver</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>			16b. SOCIAL SECURITY NO. <u>216-56-2798</u>		17. INFORMANT <u>Miss ALEXANDRIA R. ONDERDONK (SAME)</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia LLL</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic HD, ATRIAL FIBRILLATION</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>3-30, 1968</u> , to <u>3-31, 1968</u> , that (I) (we) last saw the deceased alive on <u>3-31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J Do Castro</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-31-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>J Do Castro</u>				22e. ADDRESS <u>GREATER BALTO. MED. CENTER, TOWSON, MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/3/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Balto. Co., Md.</u>				
24. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. Balto., Md. 21212</u>				25a. REC'D BY REGISTRAR DATE <u>APR 3 - 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>				



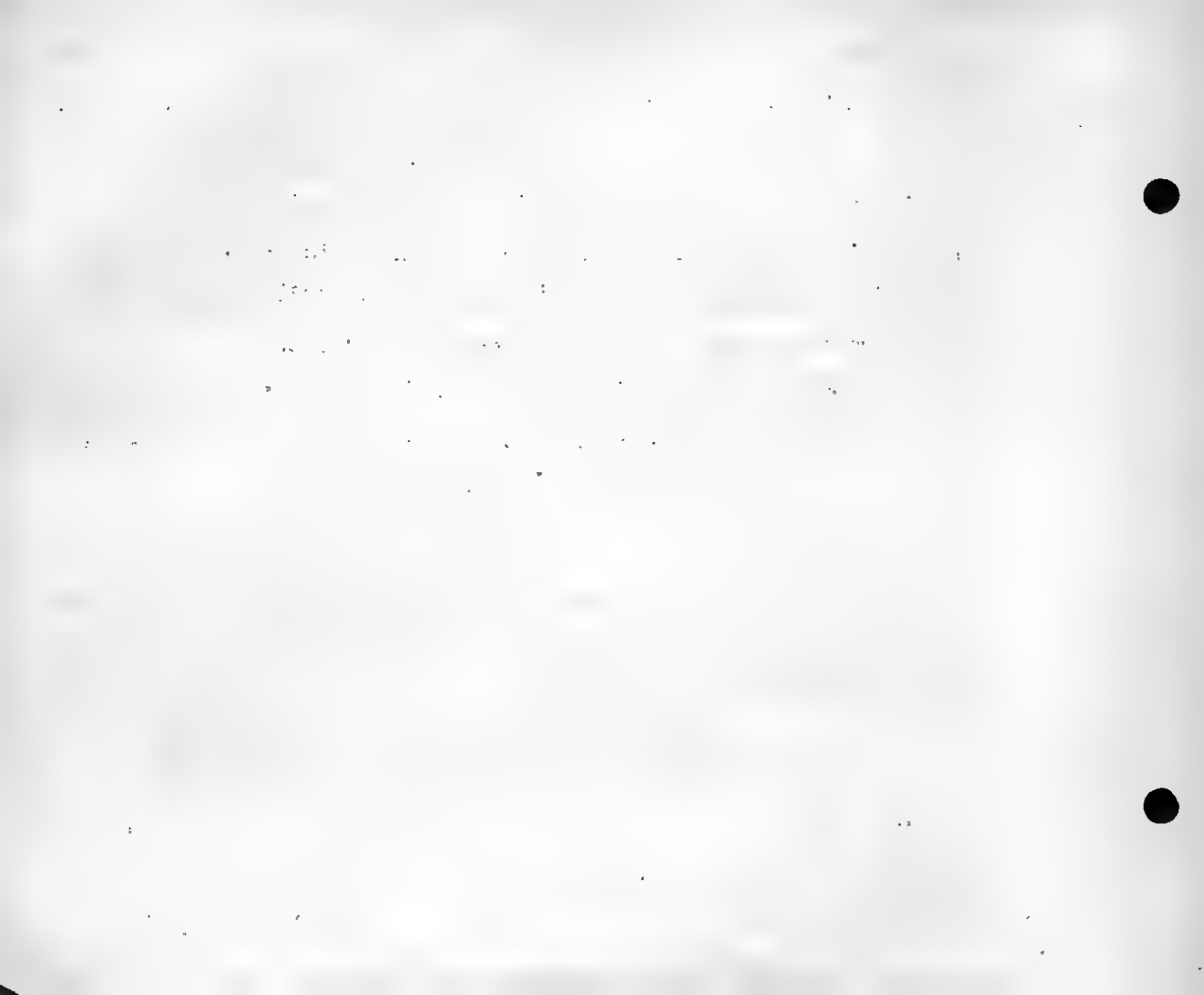
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03796

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) EMIL A ORZECH			2a. DATE OF DEATH Month March Day 20 Year 1968			2b. HOUR 3:30			
3. SEX M		4. RACE W		5. DATE OF BIRTH July 23 1893		6. AGE (in years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3028 Woodside ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) maintenance eng.		12b. KIND OF BUSINESS OR INDUSTRY St Oil			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3028 Woodside ave	
14. FATHER'S NAME First August Middle Orzech Last			15. MOTHER'S MAIDEN NAME First Henrietta Middle Pickert Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes.		16b. SOCIAL SECURITY NO WW1		17. INFORMANT Family records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Renal Vascular dis 104 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke - Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 3 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19 3-20 , 1968, that (I) (we) last saw the deceased alive on 3/20 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold H. Burns MD		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-21-68			
22d. PHYSICIAN'S NAME (Type) Harold H. Burns MD		22e. ADDRESS 8106 Harford road							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/23/68		23c. NAME OF CEMETERY OR CREMATORY Schwartz Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR C.F. EVANS & SON		ADDRESS 8802 Harford road		25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

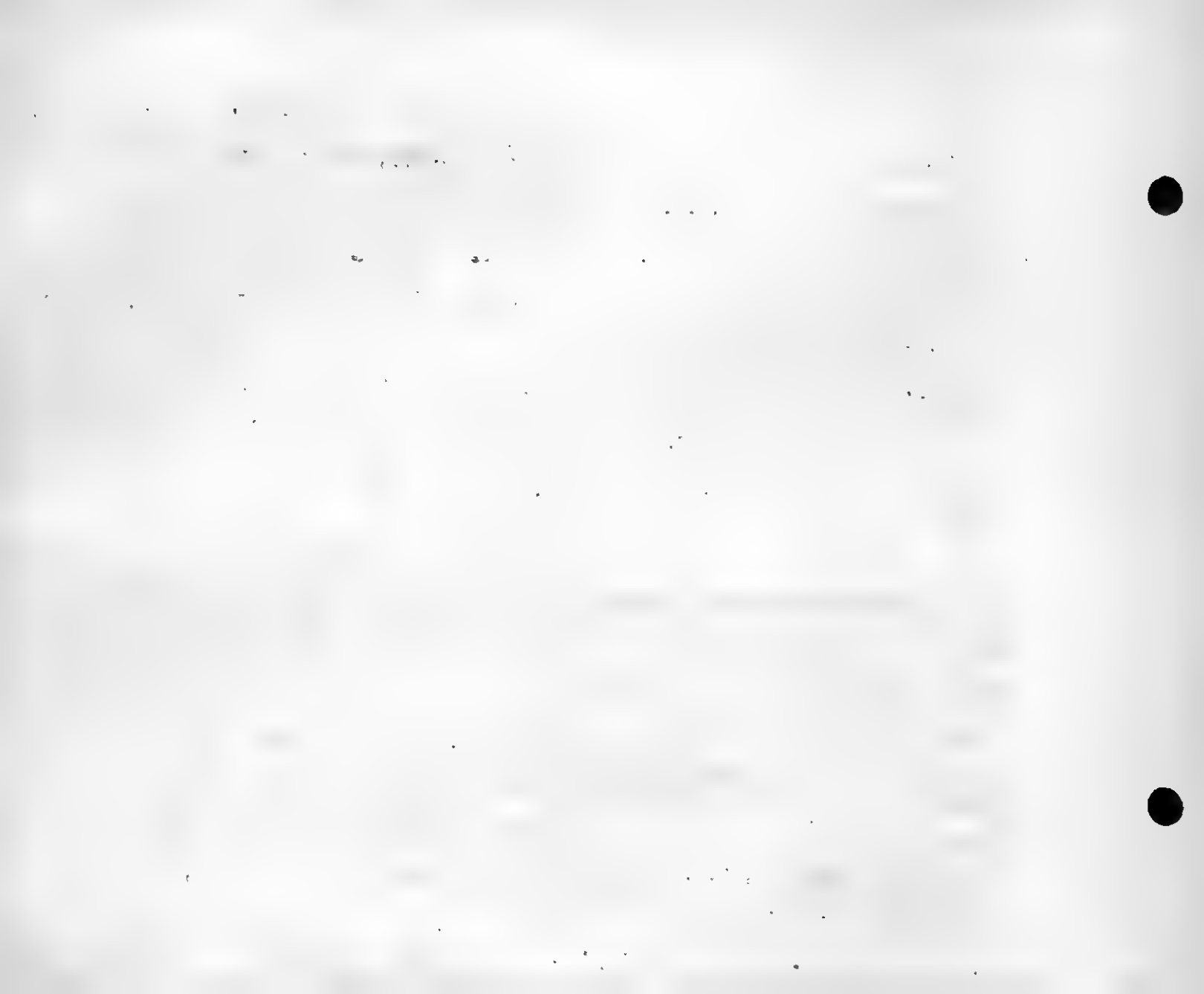


CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) HERBERT		First	Middle	Last	2a. DATE OF DEATH Month MARCH Day 16 Year 1968		2b. HOUR 1:25 M
3 SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH FEB 29, 1894			6 AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE			Md.	
10 CITY OR TOWN OF DEATH TOWSON	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STEVEDORE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE MARYLAND	13b. COUNTY -	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4821 MIDWOOD AVE.		# 21212	
14 FATHER'S NAME First Theodore	Middle PAGE	Last	15 MOTHER'S MAIDEN NAME First ?		Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 217-01-3351		17 INFORMANT THEODORE PAGE		Address 4821 MIDWOOD AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema +270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 15, 1968 , to MARCH 16, 1968 , that (I) (we) last saw the deceased alive on MARCH 16, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Yung Oh, M.D.</i>		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-16-68	
22d. PHYSICIAN'S NAME (Type) Yung Oh, M.D.		22e. ADDRESS 7620 York Road, Baltimore, Maryland 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/68		23c. NAME OF CEMETERY OR CREMATORY Union Mt. Mem. Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR <i>Joseph B. Locks Jr</i>		ADDRESS 1304 N. Central St		25a. REC'D BY REGISTRAR DAMAR 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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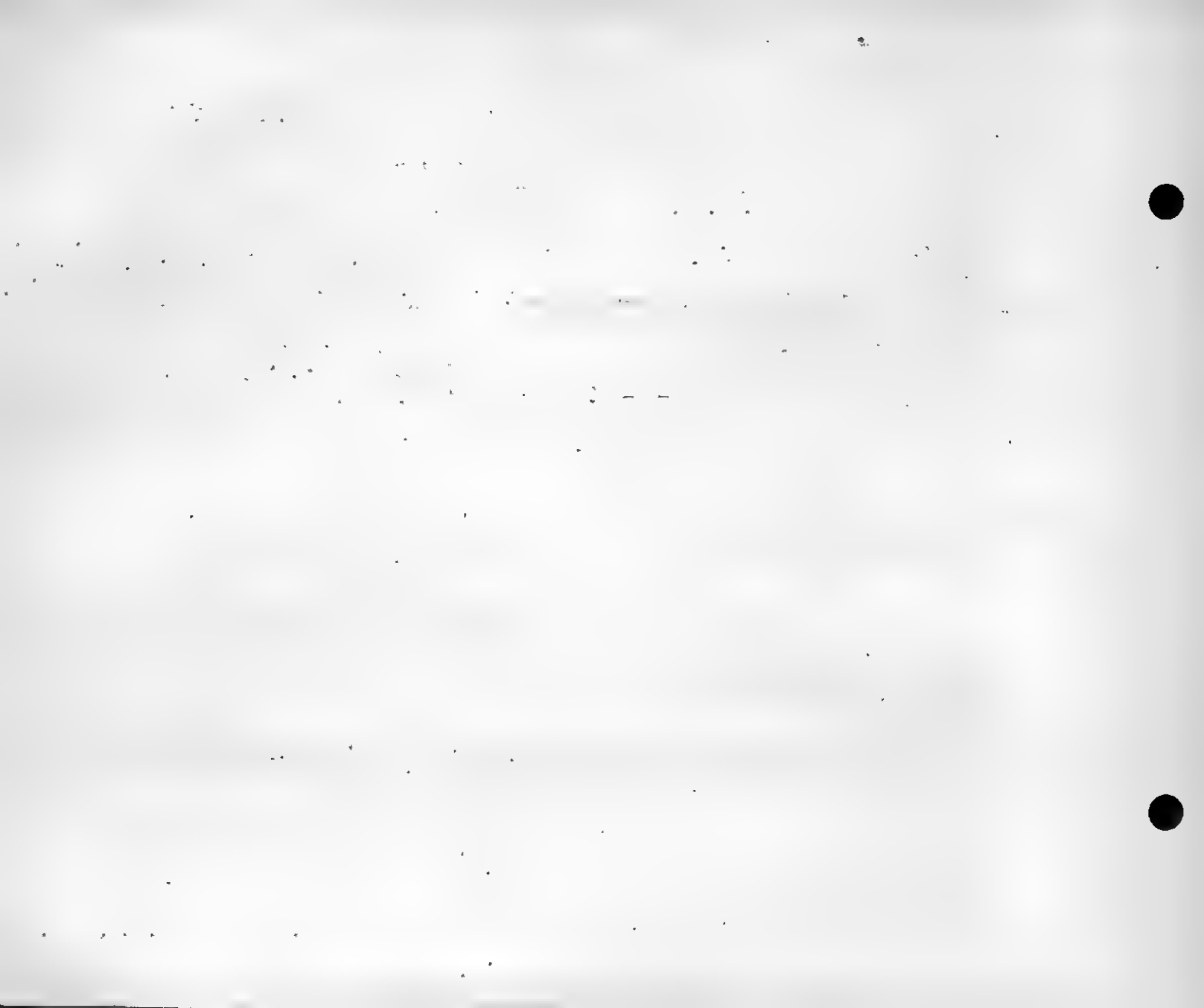
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

33798

03781

1. DECEASED-NAME (Type or print) JOHN			Middle HOLLOWELL			Last PARKER			2a. DATE OF DEATH Month Mar. Day 10 Year 1968			2b. HOUR 6:07 P.M.			
3. SEX Male			4. RACE White			5. DATE OF BIRTH Oct. 9, 1891			6. AGE (In years last birthday) 76 YRS			7. UNDER 1 YEAR MONTHS DAYS 		8. UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Director Compilation			12b. KIND OF BUSINESS OR INDUSTRY C. & P. Mgr. Telephone Co.						
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 197 Columbia Road			
14. FATHER'S NAME First John Middle Newby Last Parker			15. MOTHER'S MAIDEN NAME First Eugenia Middle Hollowell Last 												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212-10-0368 A			17. INFORMANT Ellicott City, Md. Address 21043 Mrs. Ruth H. Parker 197 Columbia Road									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from March 2, 1968 to March 10, 1968 ; that (I) (we) last saw the deceased alive on March 9, 1968 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE John A. Nesbitt Jr.			DEGREE 			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-10-68						
22d. PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR			22e. ADDRESS 109 Frederick Rd. Baltimore Md			22f. 3/12/68									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/12/1968			23c. NAME OF CEMETERY OR CREMATORY Friends Cemetery			23d. LOCATION (City or Town) (County) (State) Balto. City Balto. Co., Md.						
24. FUNERAL DIRECTOR William M. Easton Jr.			ADDRESS Catonsville, Md.			25a. REC'D BY REGISTRAR DATE MAR 14 1968			25b. REGISTRAR'S SIGNATURE John A. Nesbitt Jr.						



3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV 3/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last HARRY W. PARRISH			2a. DATE OF DEATH Month Day Year MAR 9 1968			2b. HOUR 5:30 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 3, 1885		6. AGE (In years) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH B&Tto -			
10. CITY OR TOWN OF DEATH Freeland -		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beckleysville Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Own Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto -		13c. CITY OR TOWN Freeland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Beckleysville Rd -	
14. FATHER'S NAME First Middle Last Peter Parrish			15. MOTHER'S MAIDEN NAME First Middle Last Frances Houseman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-369218		17. INFORMANT Address Mrs. Elva M. Parrish, Freeland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4:09 DUE TO, OR AS A CONSEQUENCE OF Carditis if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) G. S. C. V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of the prostate								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1958 to 3/9, 1968, that (I) (we) last saw the deceased alive on 9/9/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. M. France M.D.				22c. DATE SIGNED 3/9/68		22d. PHYSICIAN'S NAME (Type) A. M. FRANCE M.D.			
23a. BURL CREMATION, REMOVAL (Specify)		23b. DATE 3/12/68		23c. NAME OF CEMETERY OR CREMATORY Middleton Cem		23d. LOCATION (City or Town) (County) (State) Freeland Balto. Md.			
24. FUNERAL DIRECTOR Jacob Hartenstein New Freedom, Pa.				25a. REC'D BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE J. Charles, Jr.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

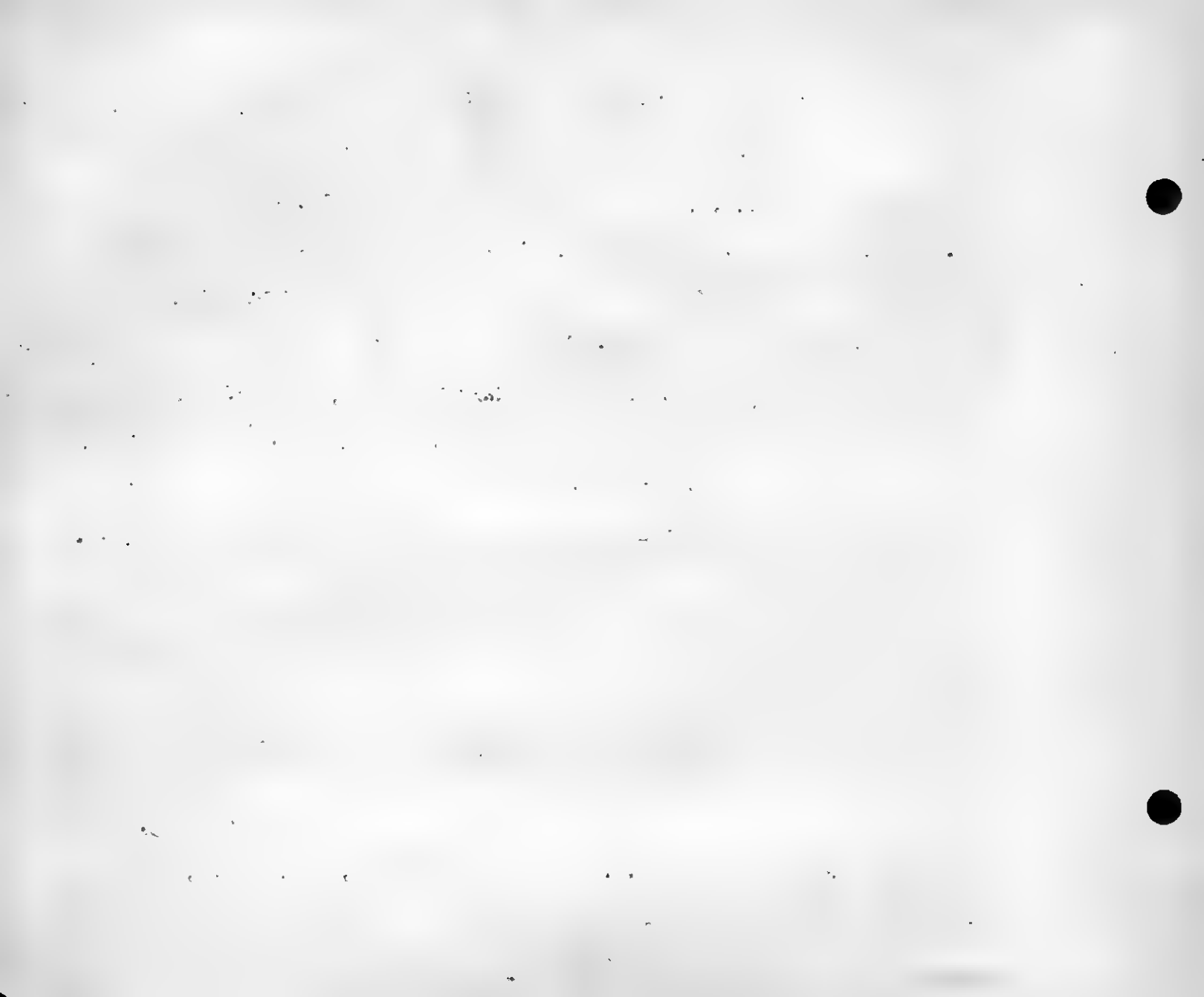
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HARRY FRANK PATTERSON			2a. DATE OF DEATH Month MARCH Day 30 Year 1968		2b. HOUR 9:40PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 26, 1911		6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH BALTIMORE		Md.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CHAUFFEUR	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY HARFORD	13c. CITY OR TOWN JOPPA	13d. INSIDE CITY, J.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 108 DURYEA DRIVE
14. FATHER'S NAME First Middle Last CHARLES PATTERSON		15. MOTHER'S MAIDEN NAME First Middle Last EMMA BERTRAM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES		16b. SOCIAL SECURITY NO WW II 216 01 50 31		17. INFORMANT Address CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF RT LUNG W/ WIDE SPREAD METASTASIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA					1 WEEK
DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHO-PNEUMONIA					1 WEEK
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (this hospital) attended the deceased from 1/2/68 , 19__, to 3/30/68 , 19__, that we saw the deceased alive on 3/30/68 , 19__, and that in our opinion death occurred on the date and hour and from the causes stated above, (we) (did) not view the body after death.					
22b. SIGNATURE <i>Pushpendra Senan M.D.</i>		DEGREE M.D.		22c. DATE SIGNED 3/31/68	
22d. PHYSICIAN'S NAME (Type) PUSHPENDRA SENAN, M.D.		22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/3/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR ULRICH FUNERAL HOME		ADDRESS 4210 BELAIR RD.		25a. REGD. BY REGISTRAR APR 4 - 1968	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

03801

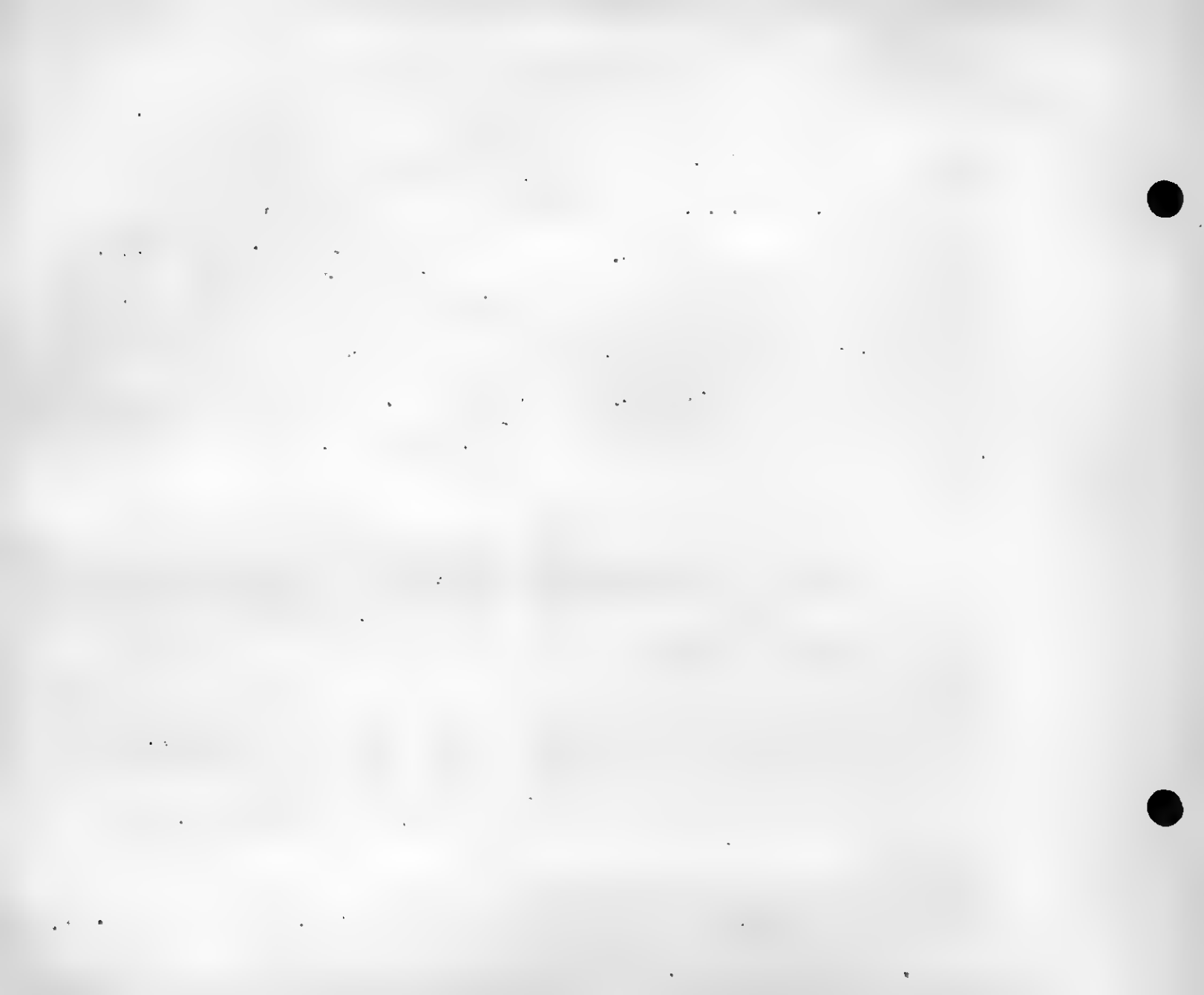
784

1. DECEASED-NAME (Type or print) First Middle Last Arnolds T Pittack			2a. DATE OF DEATH Month Day Year 3 14 1968			2b. HOUR M M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-9-1895		6. AGE (In years last birthday) 73 YRS	
7a. BIRTHPLACE (State or foreign country) Dunmore, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Interior De	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Perry Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 8622 Belair Road 36		14. FATHER'S NAME First Middle Last Adolf Pittack		15. MOTHER'S MAIDEN NAME First Middle Last Mathilda Wahlers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. 186-05-1889		17. INFORMANT Mrs Nellie W. Pittack		Address 8622 Belair Road		21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> 200.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>arterio sclerotic heart disease</u>							
19a. DATE OF OPERATION 1964		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1962</u> to <u>March 1968</u> , that (I) (we) last saw the deceased alive on <u>3-14-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-16-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-19-1968		23c. NAME OF CEMETERY OR CREMATORY Dunmore Cemetery		23d. LOCATION (City or Town) (County) (State) Dunmore Penna.	
24. FUNERAL DIRECTOR Lassabon Funeral Home 2401 Belair Road				25a. REC'D BY REGISTRAR MAR 22 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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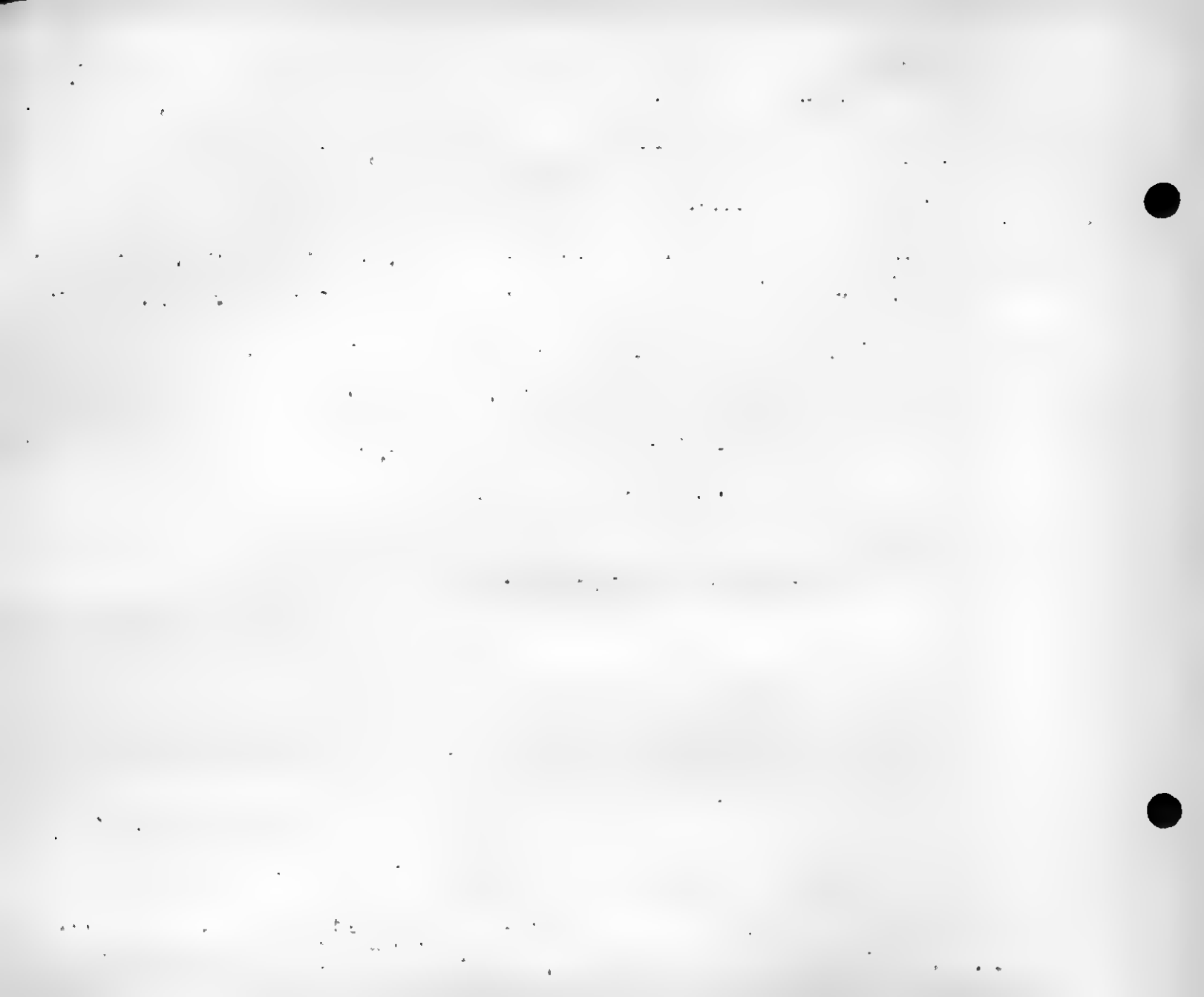
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ALBIN			First Middle Last JOSEPH PLANT		2a. DATE OF DEATH Month 26 Day 1968			2b. HOUR 5:30 M	
3. SEX MALE		4 RACE WHITE		5. DATE OF BIRTH SEPTEMBER 8, 1900		6. AGE (In years last birthday) 67 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dept. Director Audit.		12b. KIND OF BUSINESS OR INDUSTRY FED. GOV'T.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY —		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIM 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 313 WOODLAWN RD. #21210	
14. FATHER'S NAME First Middle Last William Plant			15. MOTHER'S MAIDEN NAME First Middle Last Mary T. Schuck						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 215-44-7930		17. INFORMANT Address Mrs. Ruth Frech Plant (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4222 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Intestinal perforation associated with ileus.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 21, 1968 , to MARCH 26, 1968 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on MARCH 26, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ines Cilliani</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED March 26, 1968			
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/28/68		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.			
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.				25a. REC'D BY REGISTRAR MAR 28 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

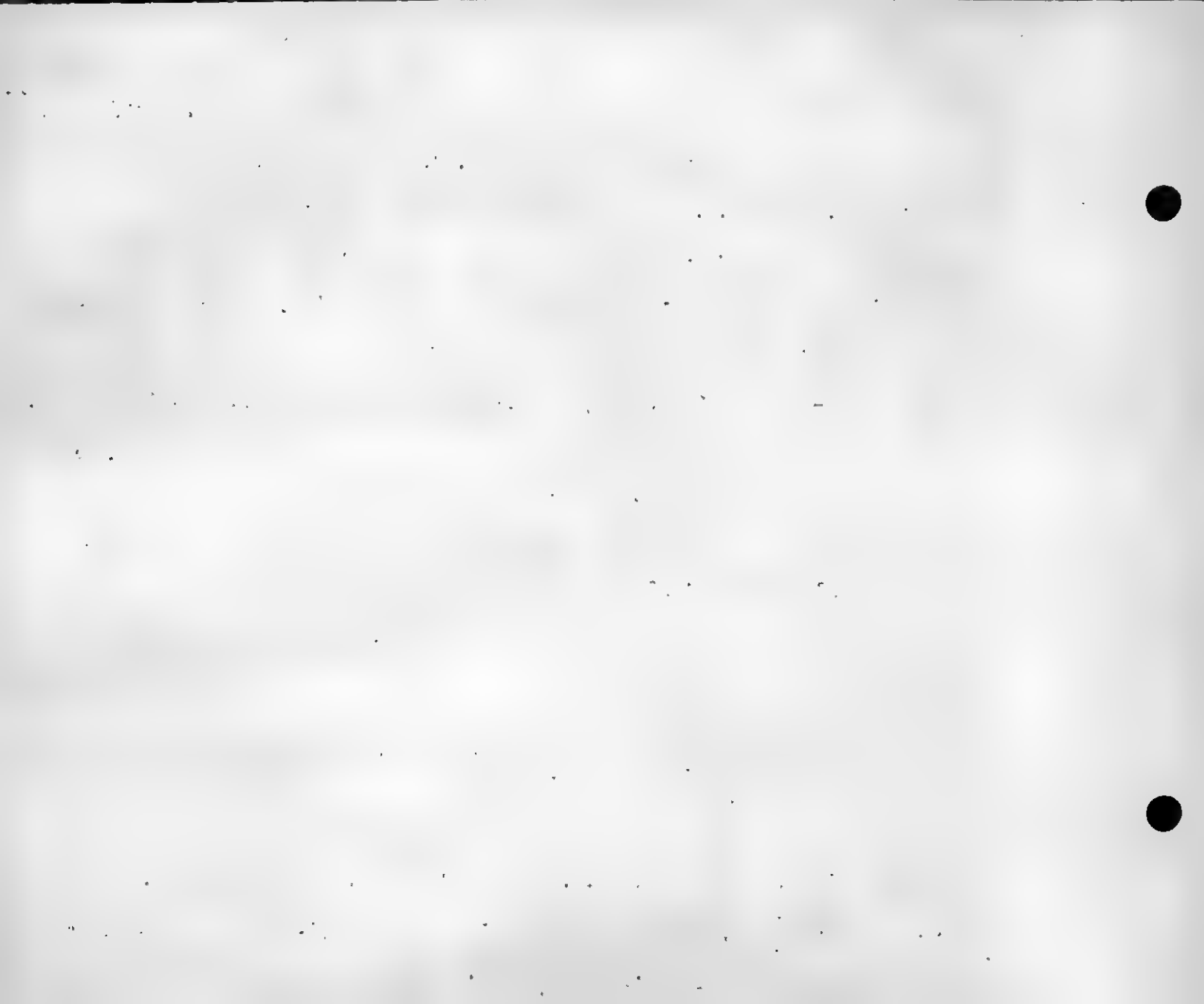


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VR 413 (4)
304M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
03786															
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M						
CHARLES			PORTER			March			22 1968 6:10						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN				
Male		Negro		Feb. 7, 1892			76 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
South Car.			U.S.A.						Baltimore						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Fort Howard				Veterans Hospital				Andy Man							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Baltimore				City				2503 Elsinor Avenue - 16			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last						
ARTHUR			PORTER			CHERI			HARRIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give year or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
Yes WW-1				218 05 72 56		Clinical Reds VA Hospital, Fort Howard, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GANGRENE, RIGHT LEG DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 weeks Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC BRAIN SYNDROME															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I (this hospital) attended the deceased from March 5, 1968, to March 22, 1968, that I (we) last saw the deceased alive on March 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.															
22b. SIGNATURE Jose A. Raquel, Jr.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/23/68						
22d. PHYSICIAN'S NAME (Type) JOSE A. RAQUEL, JR., M.D.						22e. ADDRESS VA Hospital, Fort Howard, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)							
Burial			3/27/68		Baltimore National			Baltimore Maryland							
24. FUNERAL DIRECTOR Charles H. Powell						25a. REC'D BY REGISTRAR DATE MAR 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY			First Middle Last			2a. DATE OF DEATH Month March Day 30 Year 1968			2b. HOUR 1145AM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 12-19-1888			6. AGE (In years last birthday) 79 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shady Nook Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 103 Wilson Blvd.			14. FATHER'S NAME First Luther Middle Busick Last			15. MOTHER'S MAIDEN NAME First Mary M. Middle Nazarus Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-50-5253			17. INFORMANT Address Mrs. Ethel Lowman, 103 Wilson Blvd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Cardio Vascular disease - 4104 DUE TO, OR AS A CONSEQUENCE OF (b) myocardial arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 422											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 17, 1956 , to Mar 30, 1968 , that (I) (we) last saw the deceased alive on 3-29-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harry L. Knipp MD DEGREE			22c. DATE SIGNED 4-1-68			22d. PHYSICIAN'S NAME (Type) Dr. Harry L. Knipp			22e. ADDRESS 4116 Edmondson Ave., Balto., Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 4-3-1968			23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229						25a. REC'D BY REGISTRAR DATE Apr 2 - 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
JULIUS			PRESSMAN			ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 3/12/1968		12:53 A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
male	white	9-23-1926	41 YRS			March 12, 1968		12:53 A.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
BALTO., MD.		U.S.A.				Baltimore		Md.	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
			Howard Co.-Baltimore Co. Line			CUTTER		MEAT	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Baltimore			RANDALLSTOWN		8507 GLENN MICHAEL RD. 20X8X2000XX1000X	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
HYMAN			PRESSMAN			MARY		KRITZMAN	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT		ADDRESS	
YES			W.W. 11			MRS. ANN PRESSMAN		RANDALLSTOWN	
			216-28-1643			8507 GLENN MICHAEL RD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cranio-cerebral Injury</u>									
8120 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				12:58M 3/12/68		Driver in auto-tractor trailer collision			
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		street				Baltimore, Md.			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
		Werner U. Spitz, M.D.						3/12/68	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
BURIAL		3-13-68		BALTIMORE HEWREW		REISTERSTOWN		MARYLAND	
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REG STRAR	
SOL LEVINSON & BROS., 6010 REISTERSTOWN				ROAD				25b REGISTRAR'S SIGNATURE	
				MAR 14 1968					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEASED NAME (Type or Print) WILLIAM ROBERT PRICE		2a. DATE KNOWN OF DEATH ESTI- MATED MAR 6 1968		2b. HOUR 1A
3 SEX M	4 RACE W	5 DATE OF BIRTH 4-24-01	6 AGE (In years not birthday) 66 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Sparks, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore
10. CITY OR TOWN OF DEATH SPARKS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) THORNHILL MILL RD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD.		13b. COUNTY BALTO. SPARKS	13c. CITY OR TOWN SPARKS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Robert Price		15. MOTHER'S MAIDEN NAME First Middle Last ??		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 218 03 9086		17. INFORMANT ADDRESS Robert E. Price, Sparks, Md. 21152
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION H100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5-6-68
EXAMINER'S NAME (Type) William A. Pillsbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town or county) Sparks, Md.		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 3,8,1968	23c. NAME OF CEMETERY OR CREMATORY Jessop Methodist		23d. LOCATION (City or Town) (County) (State) Sparks, Md. Baltimore
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204		25a. REC'D BY REGISTRAR MAR 7 1968		25b. REGISTRAR'S SIGNATURE Charles Young



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Gertrude	Middle B.	Last Quenzel	2a. DATE OF DEATH Month March Day 25 Year 1968		2b. HOUR 7:30 A.M.			
3. SEX F	4 RACE W		5. DATE OF BIRTH Aug. 22, 1887		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN			
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Baltimore 21212		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mercy Villa		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing				
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 708 Deepdene Road		
14. FATHER'S NAME First Douglas Middle Quenzel Last Quenzel		15. MOTHER'S MAIDEN NAME First Sevilla V. Middle Norris Last Norris		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) 217-22-4946					17. INFORMANT Address Mrs. Edna Murray, Hillcrest Ave. Hampste ad	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cerebro-Vascular Disease (b) 4-5 years DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 3-7 , 19 68 , to 3-25 , 19 68 , that (I) (we) last saw the deceased alive on 3-23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Philip D. Flynn M.D.				22c. DATE SIGNED 3-25-68		22d. PHYSICIAN'S NAME (Type) Dr. Philip D. Flynn				
22e. ADDRESS 11 E. Chase St.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR Mar 26 1968		25b. REGISTRAR'S SIGNATURE John A. Guize		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

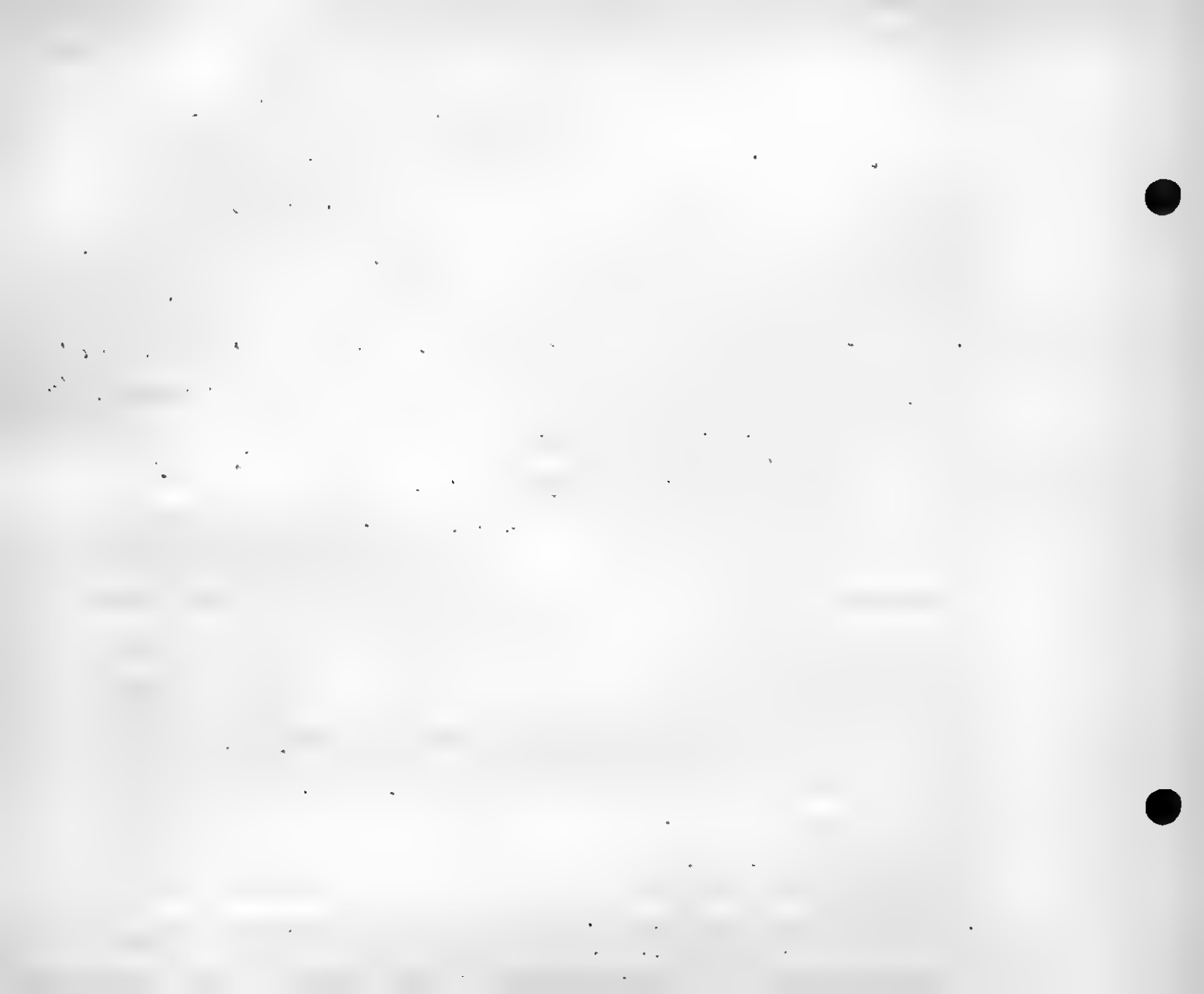
03808										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH										03791														
1. DECEASED NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Johanna					A. Quoss					March 12, 1968					2:45									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (in years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
female			white			April 14, 1879			88 YRS.			MONTHS DAYS HOURS MIN												
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
Germany			U. S.						Baltimore						Md									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY															
Catonsville			SPRING GROVE STATE HOSP.			housewife																		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER												
Md.						Balto.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3045 Strickland St.												
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Frederick					Sohn					Karnovski														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO					17. INFORMANT					Address									
No					213-10-1814					Records: SPRING GROVE STATE HOSPITAL														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Myocardial Infarction, acute															3 hrs.									
4109 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																								
(b) Arteriosclerotic Cardiovascular Ht. Dis.															20 yrs.									
DUE TO, OR AS A CONSEQUENCE OF																								
(c) Arteriosclerosis, Generalized, Senile															20 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
none.																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					City or Town County State									
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from Oct. 6, 1967, to March 12, 1968, that (X) (we) lost saw the deceased alive on March 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
Anthony J. Young, M.D.															3-12-68									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
Spring Grove State Hospital															Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					3/15/68					Loudon Park Cemetery					Baltimore, Md.									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Walters Funeral Home Pratt & Stricker															DATE MAR 15 1968					Charles Young				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) LELA			First K.		Middle R.		Last Raymond		2a. DATE OF DEATH Month March Day 3 Year 1968		
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 14, 1887			6. AGE (In years last birthday) 78 YRS.		2b. HOUR M		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Cockeysville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. Masonic Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 514 Virginia Ave.		
14. FATHER'S NAME First Monitor			Middle Hatchman		Last LELA		15. MOTHER'S MAIDEN NAME First K. Murray			Middle Murray	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. —		17. INFORMANT Records of Md. Masonic Home Cockeysville Md						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) 2. Diabetes Mellitus - 4. atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) 3. advanced arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 August 1965		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from August 1965 , to March 3 1968 , that (I) (we) last saw the deceased alive on March 2 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 3/2/68-1-23 P.M.											
22b. SIGNATURE JAMSHID HAMED		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/2/68	
22d. PHYSICIAN'S NAME (Type) J Hamed MD		22e. ADDRESS MASONIC HOME, Cockeysville Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR 5 1968		23c. NAME OF CEMETERY OR CREMATORY Spesutia				23d. LOCATION (City or Town) (County) (State) Perryman Md			
24. FUNERAL DIRECTOR W Cook Brooks Towson		ADDRESS 1050 York Rd Towson Md 21204		25a. REC'D BY REGISTRAR MAR 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) MAMIE		First		Middle		Last		2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Mar 27 1968		2b HOUR 11:10 AM	
3 SEX Female		4 RACE W		5 DATE OF BIRTH 2/21/09		6 AGE (a years last birthday) 79 YRS		7 UNDER 1 YEAR MONTHS 0 DAYS 0		8 IF UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.					
10 CITY OR TOWN OF DEATH Mt. Wilson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt Wilson Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
13a U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE md.		13b COUNTY U		13c CITY OR TOWN Balto		3a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1815 Balto. St			
14 FATHER'S NAME Johny		First		Middle		Last		15 MOTHER'S MAIDEN NAME Jennie Walters		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO. ---		17 INFORMANT accident Report - So. Balto. Gen. Hosp		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia. 011.9 DUE TO, OR AS A CONSEQUENCE OF Cor Pulmonale Conditions if any which gave rise to immediate cause (a), stating the underlying cause last Pulmonary Tho. (b) 6 mt. (c) 4 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 da.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 0021 None.											
19a DATE OF OPERATION None.		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTR.B.ING <input type="checkbox"/> CAUSE OF DEATH None.		21b TIME OF INJURY Month, Day, Year None.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) None.		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE D. D. Caples		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 3/27/68	
EXAMINER'S NAME (Type) D. D. CAPLES		M.D.		ADDRESS (Street city, town or county) Restoration, Balto.							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 3/30/68		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK		23d. LOCATION (City or Town) Baltimore		(County) md.		(State)	
24 FUNERAL DIRECTOR McLilly		ADDRESS 130 E. Fort Ave Balto.		25a RECD BY REGISTRAR DATE MAR 29 1968		25b REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

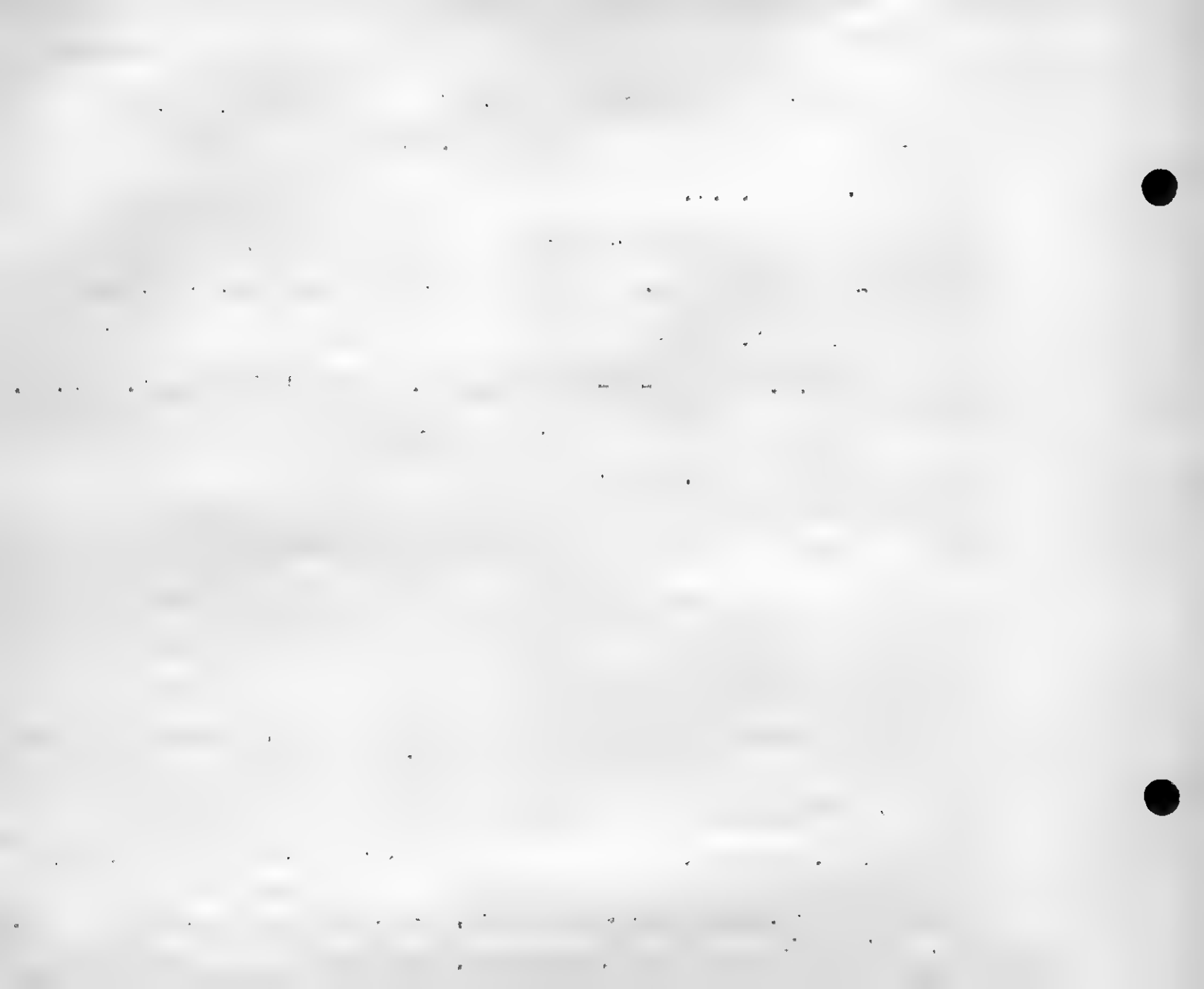
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Gold en Baker Rhodes			2a. DATE OF DEATH Month March Day 14 Year 1968			2b. HOUR 7 A M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 10, 1896		6. AGE (In years last birthday) 71 YRS.		7. UNDER 1 YEAR MONTHS 1 DAYS 14		IF UNDER 24 HRS HOURS 7 MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Reisterstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 109 Second Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cabinet Maker			12b. KIND OF BUSINESS OR INDUSTRY Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 109 Second Avenue		
14 FATHER'S NAME First Middle Last John A. Rhodes			15 MOTHER'S MAIDEN NAME First Middle Last Ettie Baker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO W.W.I 214-24-8913		17 INFORMANT Address Vada E. Rhodes 109 2nd Ave. Peis. Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 342X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parkinson's Disease DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 20 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 3501											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9-21-48 , 19____, to 3-14-68 , 19____, that (I) (we) last saw the deceased alive on 2-15-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D. D. Caples						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-15-68			
22d. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.						22e. ADDRESS 6 Hanover Rd., Reisterstown, Md. 21136					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens Finksburg, Carroll, Md.		23d. LOCATION (City or Town) (County) (State) Owings Mills, Maryland.		25a. REC'D BY REGISTRAR H. J. Eckhardt			
24. FUNERAL DIRECTOR H. J. Eckhardt		25b. REGISTRAR'S SIGNATURE J. Charles Jones		25c. DATE MAR 18 1968							

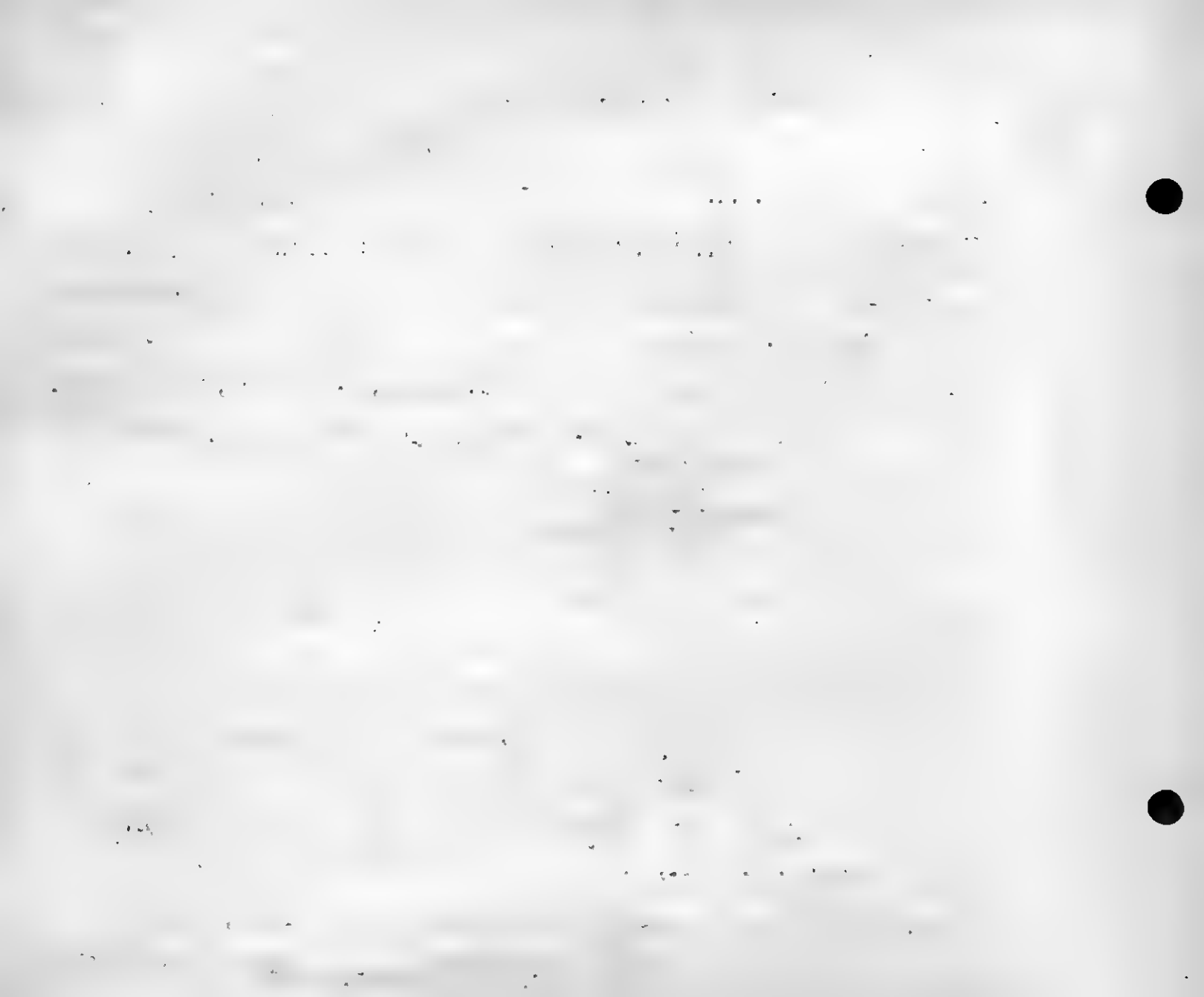


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-7-61
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First HERBERT			Middle ANDREW			Last RITTER		
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH 10/5/96			2a. DATE OF DEATH Month 3 Day 26 Year 68		
7a. BIRTHPLACE (State or foreign) BALTIMORE			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY,		
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY OIL COMPANY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN DUNDALK			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First WILLIAM A. Middle RITTER Last RITTER			15 MOTHER'S MAIDEN NAME First MARTHA Middle MC CULLOUGH Last MC CULLOUGH			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes give war or dates of service) YES WW I			16b. SOCIAL SECURITY NO. 705 09 29 43		
17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ADENOCARCINOMA LEFT LUNG WITH LYMPH NODE METASTASIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) BRONCHOPNEUMONIA (c) NEPHROSCLEROSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from 2/27/68 , 19 68 , to 3/26/68 , 19 68 , that he (we) last saw the deceased alive on 3/26/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) not view the body after death.											
22b. SIGNATURE Ahmed Kuty			22c. DATE SIGNED 3/26/68			22d. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D.			22e. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE MAR. 28, 1968			23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR			ADDRESS ULLRICH FUNERAL HOME			25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE Charles Judge		

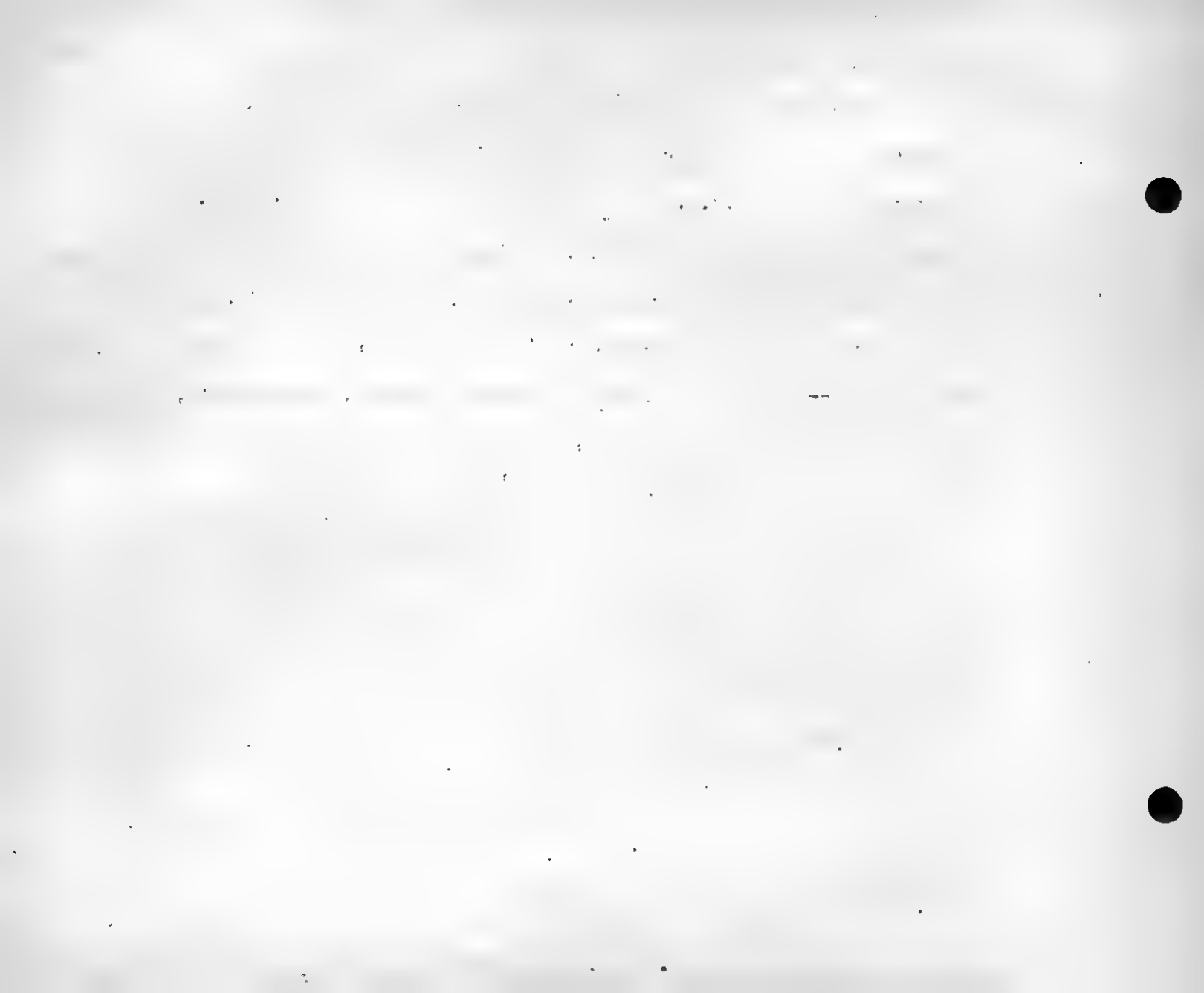


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Arlethia Ann ROBBINS		2a. DATE OF DEATH Month Day Year 3 18 68		2b. HOUR 11:40 PM
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 7/20/49	6. AGE (In years last birthday) 18 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dependent	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Joe Robbins		15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) no --		16b. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7429 IMMEDIATE CAUSE (a) Pneumonia, suspected DUE TO, OR AS A CONSEQUENCE OF (b) Convulsive Disorder DUE TO, OR AS A CONSEQUENCE OF (c) Congenital Cerebral Defect (frontal lobes) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 11-11				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (X) (this hospital) attended the deceased from 12/27 , 19 54 , to 5/18 , 19 68 , that (X) (we) lost saw the deceased alive on 3/18 , 19 68 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death				
22b. SIGNATURE Lucrecia F. Joven, M.D.		22c. DATE SIGNED 3-29-68		22d. PHYSICIAN'S NAME (Type) LUCRECIA F. JOVEN, M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-1-68		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School
24. FUNERAL DIRECTOR David Funeral Home, Pikesville, Md.		25a. REC'D BY REGISTRAR APR 3 1968		25b. REGISTRAR'S SIGNATURE Charles Young



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

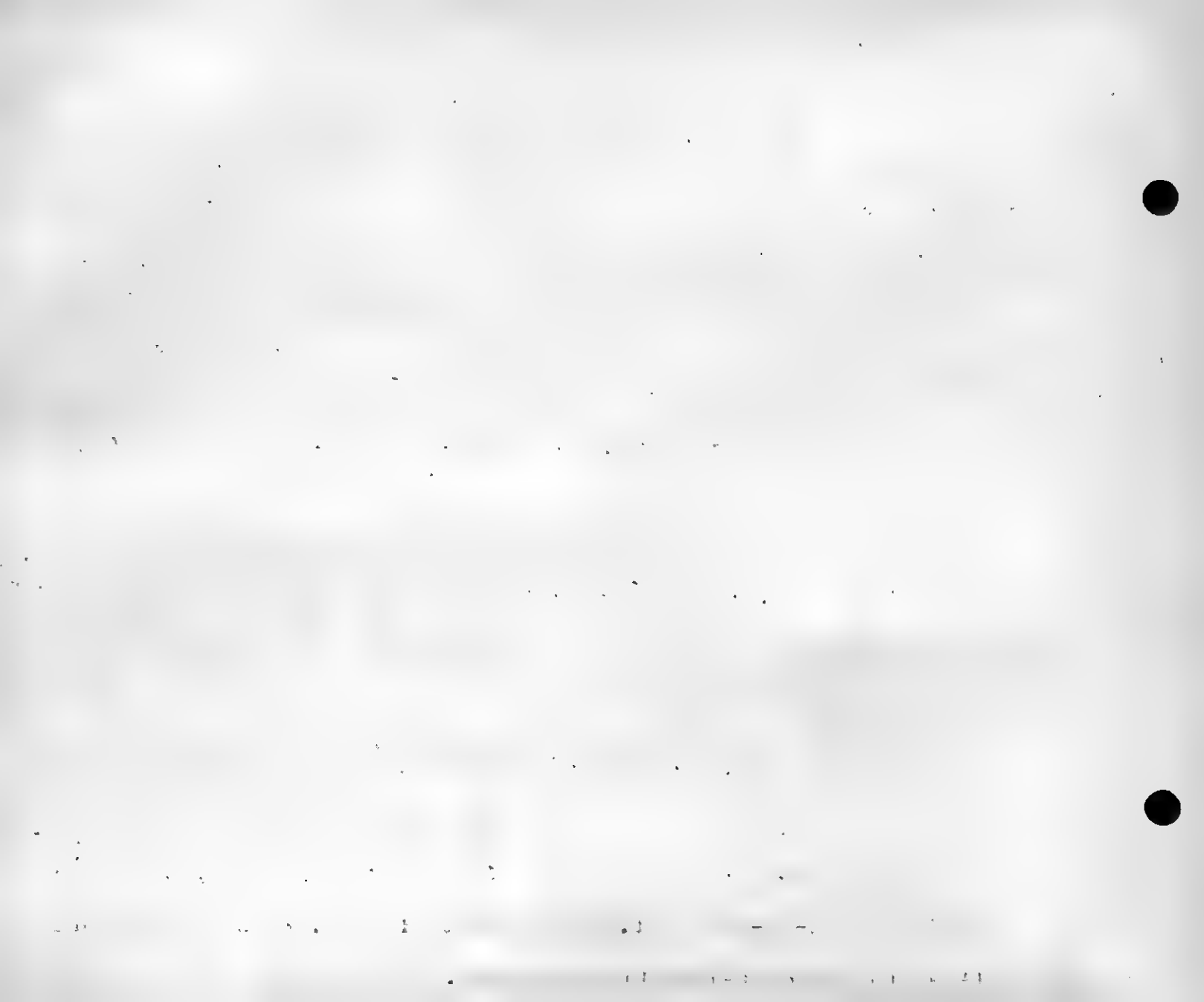
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Henry	Middle August	Last ROCK	2a. DATE OF DEATH Month March Day 25 Year 1968			2b. HOUR 3:45PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 23, 1881		6. AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,			Md
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clothing Cutter		12b. KIND OF BUSINESS OR INDUSTRY Clothing			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1313 Malbay Drive	
14. FATHER'S NAME First Charles Middle M. Last Rock			15. MOTHER'S MAIDEN NAME First Fredericka Middle Wurmstick Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 216-36-4733A		17. INFORMANT Address Family Records					
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 427.0 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 434.1 Pulmonary emphysema									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/19/ , 19 68 , to 3/25/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/25/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Reynaldo Orjuela Gomez, M.D.					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED March 25, 1968		
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela Gomez, M.D.					22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) BURIAL		23b. DATE Mar. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204					25a. REC'D BY REGISTRAR DATE MAR 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) ALmon T Ross					2a. DATE OF DEATH Month March Day 24 Year 68			2b. HOUR 6:30 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb 16, 1881		6. AGE (in years last birthday) 87 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	
7a. BIRTHPLACE (State or foreign country) California		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Balto Md.			
10. CITY OR TOWN OF DEATH Holbrook		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maritime administrator		12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. USUA. RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Ind		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4114 Bonis Road	
14. FATHER'S NAME First Alexander Middle Ross Last Hattie				15. MOTHER'S MAIDEN NAME First M. Sherman Middle Sherman Last Sherman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes WW1		16b. SOCIAL SECURITY NO 213-10-2696A		17. INFORMANT Harriett Ross Sorrell Address 4114 Bonis Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4124 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) HEMIPARESIS RIGHT AND APHASIA DUE TO CEREBROVASCULAR ACCIDENTS (1961, 1963)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from FALL 1957 to MARCH 1968 , that (I) (we) last saw the deceased alive on MARCH 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marvin Goldstein				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED MARCH 24, 1968			
22d. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN		22e. ADDRESS 6001 PARK HEIGHTS AVE. BALTO. MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-30-68		23c. NAME OF CEMETERY OR CREMATORY St. Helena Cemetery		23d. LOCATION (City or Town) (County) (State) St. Helena California i			
24. FUNERAL DIRECTOR Ellsworth Armacost		24b. ADDRESS 4600 Liberty Hgts. Ave		25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

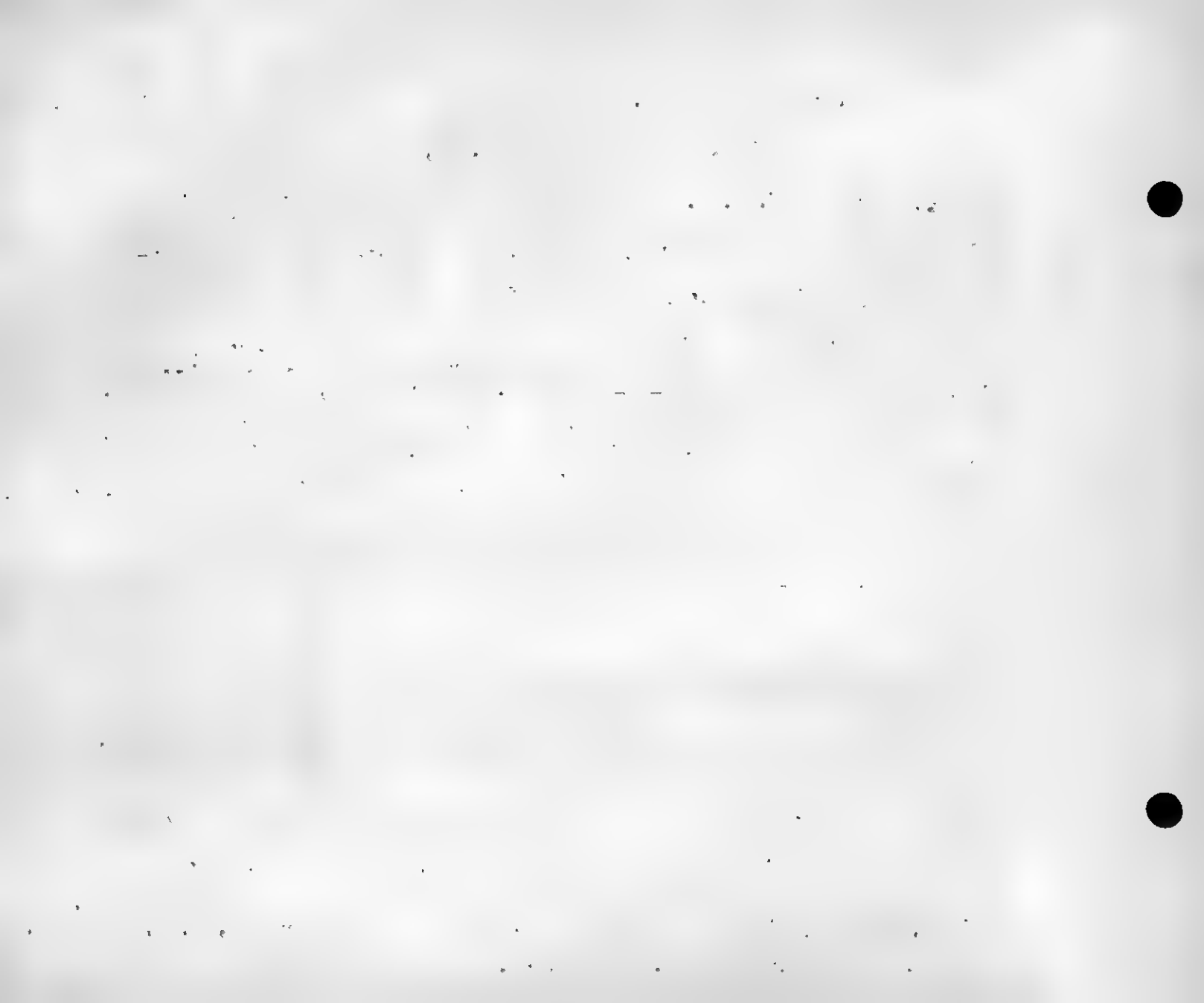


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Mary			First Middle Last E. Roub		2a. DATE OF DEATH Month Day Year March 12 1968			2b. HOUR 9:00AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 26, 1902		6. AGE (in years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2803 Ritchie Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sewing Machine Operator- Shoe			12b. KIND OF BUSINESS OR INDUSTRY Factory		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Pennsylvania		13b. COUNTY Blair		13c. CITY OR TOWN Martinsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 118 Mansard Street	
14. FATHER'S NAME First Middle Last Emmanuel Glass			15. MOTHER'S MAIDEN NAME First Middle Last Not Known						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO 210-24-9144A		17. INFORMANT (Relationship) Edgemere, Md. 21219 Mrs. Pauline Butts, 2803 Ritchie Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Aneurysm</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5-6p</u>	
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 20, 1968</u> to <u>March 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. G. Windsor</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/12/68			
22d. PHYSICIAN'S NAME (Type) ROGER G. WINDSOR				22e. ADDRESS 520 DSt. Balt, 19, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/68		23c. NAME OF CEMETERY OR CREMATORY Brumbaugh Cemetery		23d. LOCATION (City or Town) (County) Pa. (State) Martinsburg, R. D. Blair Co.			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR MAR 18 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Helen		First Middle Last		2a. DATE OF DEATH 3 Month I Day 68 Year		2b. HOUR 5 A M	
3. SEX F		4. RACE W		5. DATE OF BIRTH I-24-1984		6. AGE (In years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 7148 Martell Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME J First ? Middle Jadczak Last		15. MOTHER'S MAIDEN NAME unknown First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-05-8198 D		17. INFORMANT Mrs. Marie Leasure Address as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 582 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic nephritis (b) Chronic nephritis DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DUODENAL ULCER.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1960 to Nov 1968 , that (I) (we) lost the deceased alive on Feb 28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen D. Mackowiak DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3-2-68			
22d. PHYSICIAN'S NAME (Type) Dr. Stephen Mackowiak				22e. ADDRESS 6714 Holibird Avenue, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-5-1968		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Walter Dabrowski		ADDRESS 1005 Dundalk Avenue		25a. REC'D BY REGISTRAR MAR 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



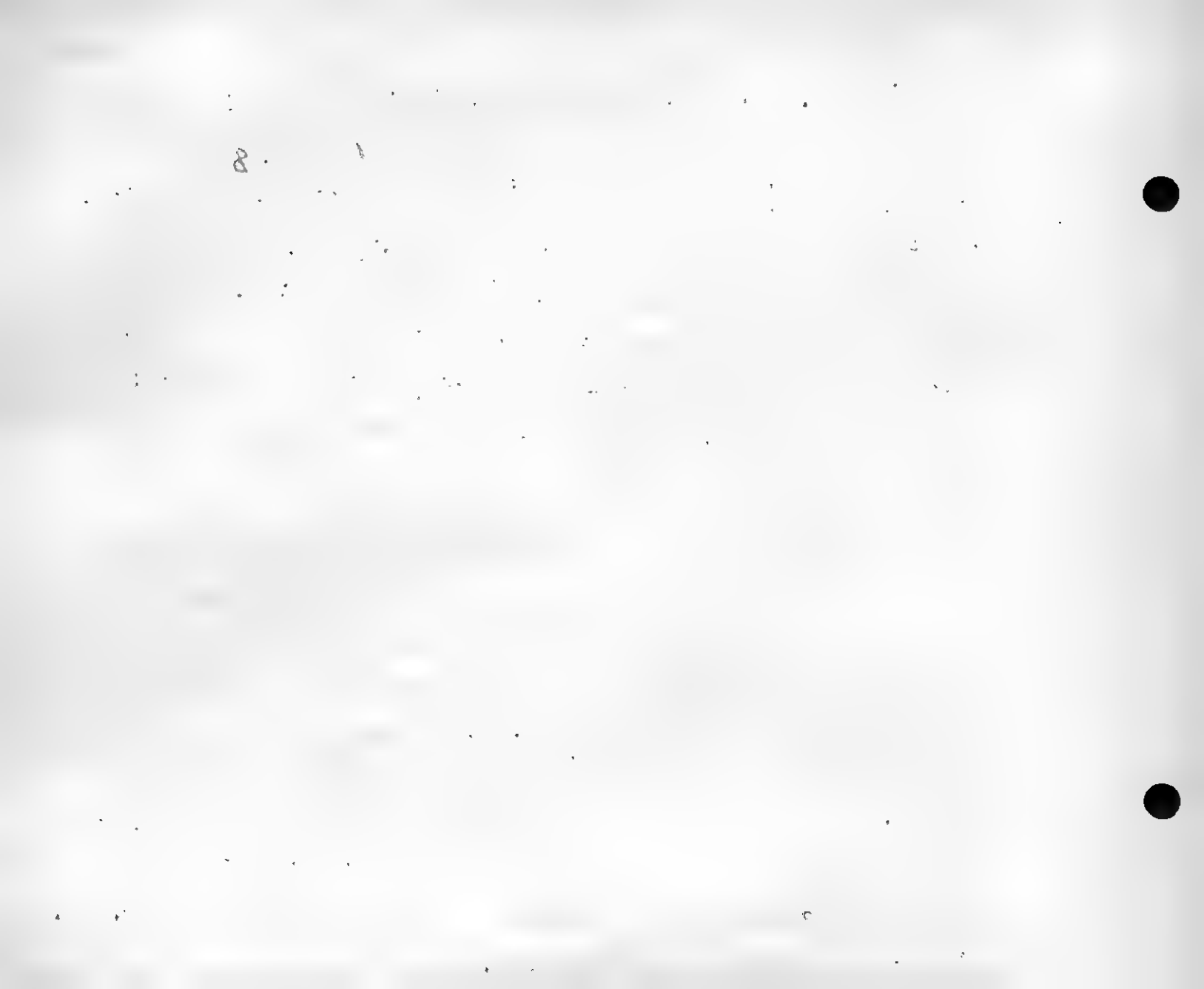
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) WILLIAM ARTHUR SAUNDERS			2a. DATE OF DEATH Month 3 Day 18 Year 68		2b. HOUR 9:58 M
3 SEX Male	4 RACE Negro	5. DATE OF BIRTH 5.1.1908		6. AGE (In years last birthday) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Norfolk Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Mount Baltimore Co., Md.	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Dorchester Cambridge	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 606 Wells Str.
14. FATHER'S NAME First Middle Last JESSIE SAUNDERS		15. MOTHER'S MAIDEN NAME First Middle Last MATTIE STATION			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. 214-07-8263		17. INFORMANT Address Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 16a1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1.4 , 19 68 , to 3.18 , 19 68 , that (I) (we) lost saw the deceased alive on 3.18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W Newcomer				22c. DATE SIGNED 3.18.1968	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/24/68	23c. NAME OF CEMETERY OR CREMATORY WAUGH		23d. LOCATION (City or Town) (County) (State) CAMBRIDGE DOR. MD.
24. FUNERAL DIRECTOR Fredrick C. Deloit			25a. REC'D BY REGISTRAR D MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

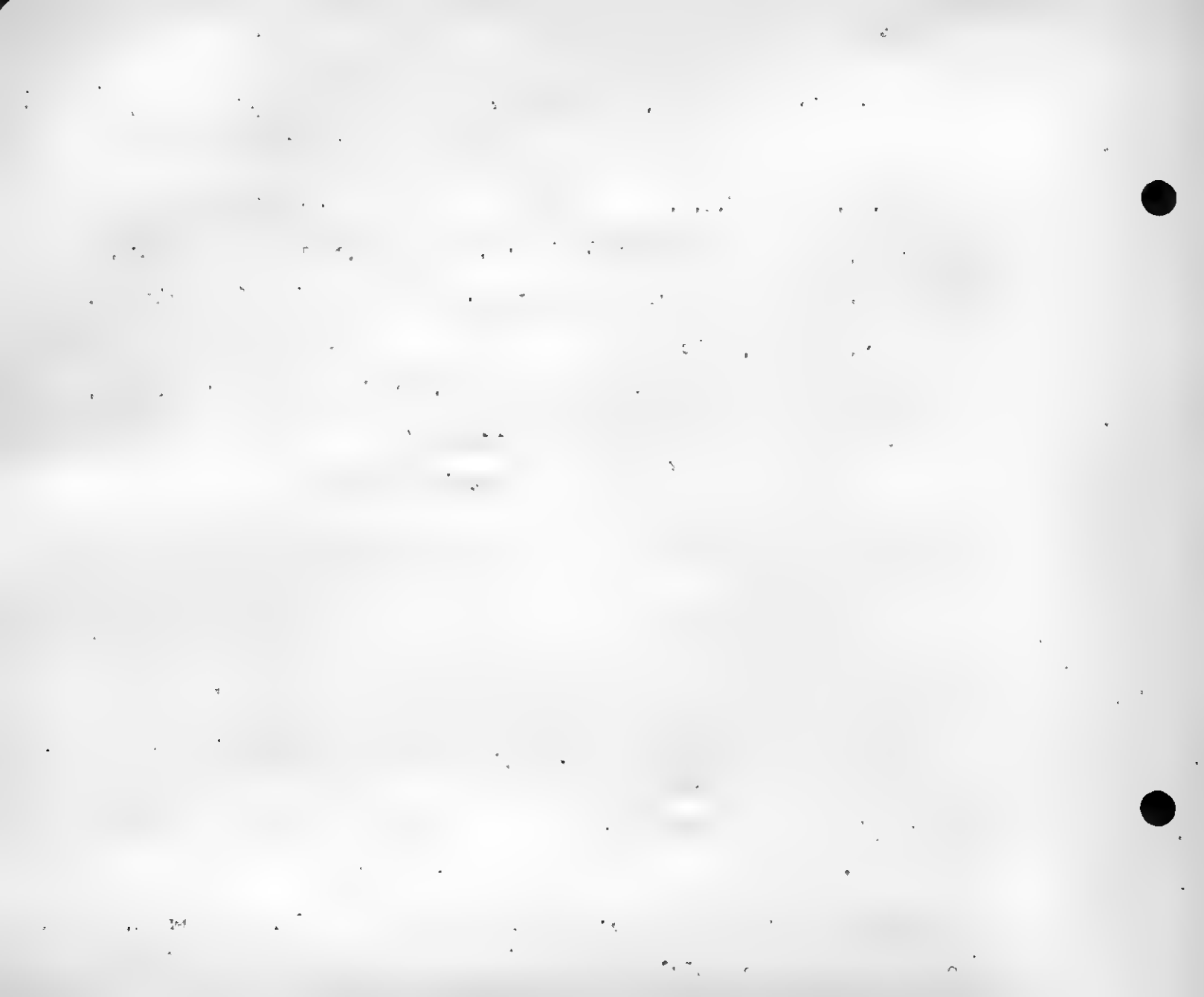


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VR 151-1
30M REV 1-60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
03802															
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR				
William			T.		Schmitz				Month 3 Day 27 Year 1968		10 ⁰⁰ A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR				
Male			White			October 30, 1903			84 YRS.		MONTHS DAYS HOURS M.N.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Balto., Md.			U.S.A.						Baltimore			Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR IND. STRY						
Catonsville.			5504 Knoll View Ct.			Journal Clerk			Md., Leg.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY, UNITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Md.			Baltimore			Catonsville			X		5504 Knoll View Ct.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Wm. F. Schmitz			Rosanna Thomas												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No			213 34 5945			Grace M. Schmitz			5504 Knoll View Ct.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11/25</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>72</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>March</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>Jan.</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.															
22b. SIGNATURE <u>Lester A. Wall Jr. MD</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>3/29/68</u>						
22b. PHYSICIAN'S NAME (Type)			22e. ADDRESS												
Dr. Lester Wall			1039 St. Paul St.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			4/1/1968			Loudon Park Cemetery			3801 Frederick Rd. Balto., Md						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Mitchell Wiedefeld Home			6500 York Rd. Balto. Md			APR 2 - 1968			<u>Charles Judge</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

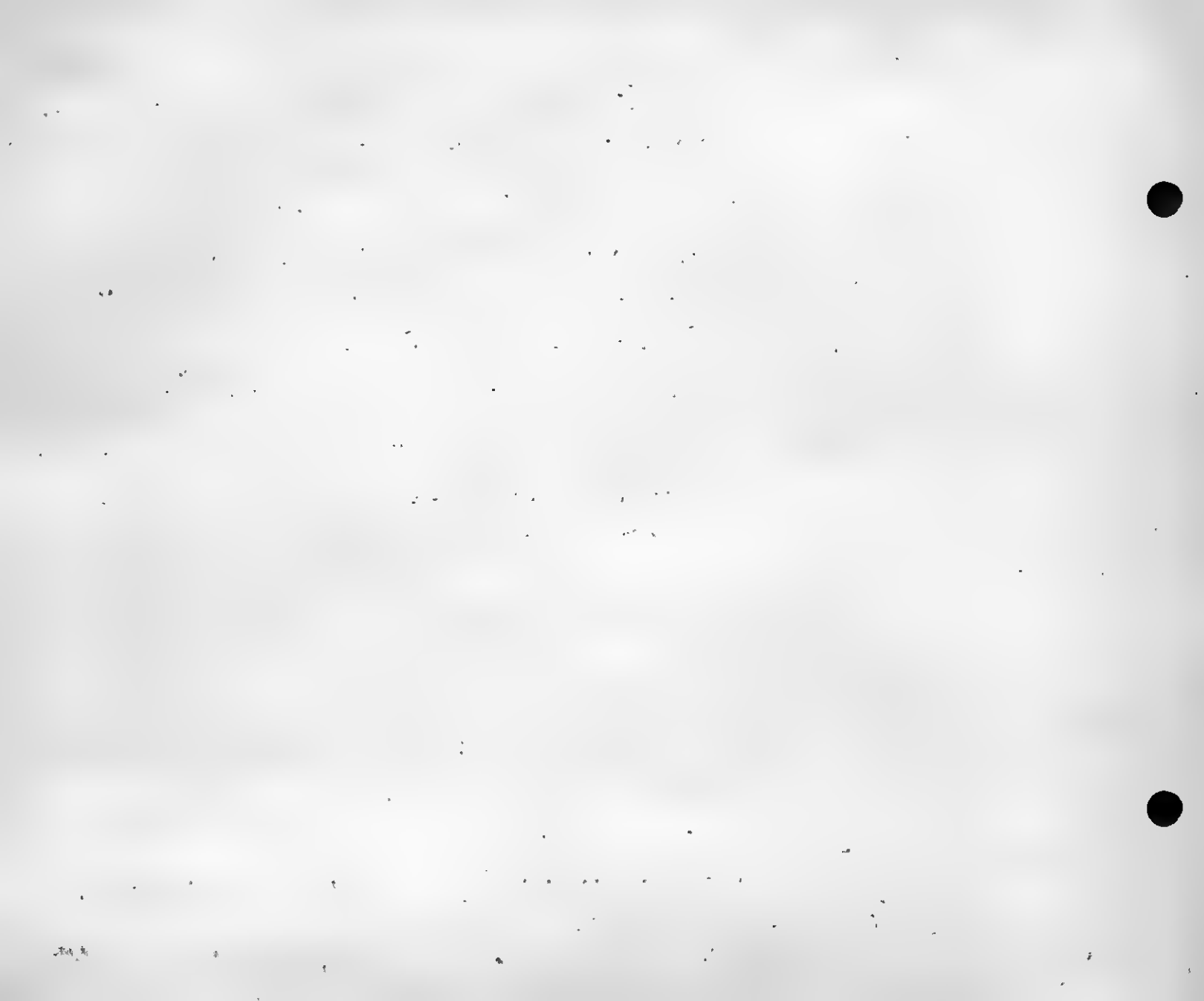
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13
304M R11
1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Vincent		First R. Middle S. Last Schuerholz		2a DATE OF DEATH Month MARCH Day 25 Year 1968		2b. HOUR 12:25A	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 8-28-1876		6 AGE (In years last birthday) 91 YRS.	
7a. BIRTHPLACE (State or foreign country) Balto. Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Balto Co.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - National		12b. KIND OF BUSINESS OR INDUSTRY name of Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Balto		13c. CITY OR TOWN Ward Chapel Rd. - Marriottsville, P.O. Md		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First August Middle Schuerholz Last Schuerholz		15 MOTHER'S MAIDEN NAME First Barbara Middle Schuerholz Last Schuerholz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 216-07-7628		17. INFORMANT Mr. Leroy N. Schuerholz Address Ward Chapel Rd. Box 65 H Marriottsville P.O. Md. 21104			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 4120 DUE TO, OR AS A CONSEQUENCE OF (b) GENERAL ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED SENILE DETERIORATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30+ yrs 30+ yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 44							
19a. DATE OF OPERATION 44		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (myself) attended the deceased from 1960 , 19 1960 , to March 25, 1968 , that (I) (we) last saw the deceased alive on 24 March 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. H. Lawson, Jr., M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 25/March/68	
22d. PHYSICIAN'S NAME (Type) William H. Lawson, Jr., M.D.		22e. ADDRESS Box 54, RD #2, Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-28-68		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Balto. Md	
24. FUNERAL DIRECTOR Young Byers Chapel - 8728 Liberty Road		ADDRESS		25a. REC'D BY REGISTRAR DATE Mar-2-8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last KATIE SCHUMAN			2a. DATE OF DEATH Month 3 Day 9 Year 68		2b. HOUR 8:10 AM
3. SEX FEMALE	4. RACE WHITE		5. DATE OF BIRTH		6. AGE (In years last birthday) 71 YRS.
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH BALTIMORE		Md			
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET AND NUMBER 130 SLADE AVE.		APT. 216			
14. FATHER'S NAME First Middle Last HARRY MORSTEIN			15. MOTHER'S MAIDEN NAME First Middle Last FANNIE SCHERR		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) NO		16b. SOCIAL SECURITY NO 213-05-6933		17. INFORMANT MR. IRVING SCHUMAN, 28 MILLSTONE ROAD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prob. Ac Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF RETROVIRUS CELL SARCOMA (b) 7 MOS. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 67		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov , 19 67 , to March 9 , 19 68 , that (I) (we) last saw the deceased alive on Mar 7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Daniel DAKAL MD		22c. DATE SIGNED 3-9-68		22d. PHYSICIAN'S NAME (Type) DANIEL DAKAL, MD.	
22e. ADDRESS 5600 Lochearn Dr. Balto Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-10-68		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH AITZ KCHAIM	
23d. LOCATION (City or Town) BALTIMORE		23e. COUNTY MARYLAND		23f. STATE MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN		24a. ADDRESS ROAD		24b. REC'D BY REGISTRAR DATE MAR 12 1968	
24c. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First Howard		Middle John		Last Schwabland		2a DATE OF DEATH Month March Day 2 Year 1968		2b HOUR 10:40
3. SEX Male		4 RACE White		5 DATE OF BIRTH 12/11/23		6 AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		Md.		
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard		12b KIND OF BUSINESS OR INDUSTRY Martin Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 2233 Old Eastern Ave.		
14. FATHER'S NAME First Peter Middle J. Last Schwabland		15. MOTHER'S MAIDEN NAME First Bertha Middle Weakland Last Weakland								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO 216-12-2297		17. INFORMANT Mrs. Virginia Greenfield		Address 133 Lyndale Ave. #36				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary abscess/ Pulmonary tuberculosis										
DUE TO, OR AS A CONSEQUENCE OF (b) Malnutrition										
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic alcoholism										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (A) (this hospital) attended the deceased from March 2, 1968 , to March 2, 1968 , that (A) (we) last saw the deceased alive on March 2, 1968 , and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.										
22b. SIGNATURE L. Misanik		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/3/68				
22d. PHYSICIAN'S NAME (Type) Lawrence Misanik, M.D.		22e. ADDRESS 7620 York Rd. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/7/68.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md				
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR MAR 4 1968		25b. REC'D BY REGISTRAR John				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-433, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 2a Film G398 3/10/68											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) a/k/a First Charles Wesley Middle Shaw Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 10 Year 1968			2b HOUR M		2c DATE PRONOUNCED DEAD Month March Day 11 Year 1968			2d HOUR 8:00	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Sept. 23, 1944		6 AGE (In years last birthday) 23 YRS		7 UNDER 24 HRS MONTHS DAYS HOURS MIN.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		9 COUNTY OF DEATH Balto.		10 CITY OR TOWN OF DEATH Balto.		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Grounds Spring Grove St. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRAINER	
13a USUAL RESIDENCE (Where deceased lived, if not institution Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Sparks		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Belfast Rd.		12b KIND OF BUSINESS OR INDUSTRY Horses	
14 FATHER'S NAME First Charles Middle Wesley Last Shaw, Jr.		15 MOTHER'S MAIDEN NAME First MARIANNE Middle Stowell Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO unknown		17 INFORMANT (Uncle) 897-1603 Mr. Alexander Shaw		ADDRESS 805 Oak Joppa Road Joppa, Maryland 21085	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to hanging											
953 X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year ? ? 19 ? P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject hanged himself			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Grounds of Hospital				21f. LOCATION Street or R.F.D. No Catonsville City or Town Balto. State Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Edward F. Wilson</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED March 11, 1968			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE March 13, 1968				23c. NAME OF CEMETERY OR CREMATORY St. Mary's Episcopal Church Cem.			
23d. LOCATION (City or Town) Emmorton				(County) Harford Co.				(State) Maryland			
24. FUNERAL DIRECTOR Joseph William Foster				25a. REC'D BY REGISTRAR MAR 14 1968				25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file in the space provided. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-64
30M REV. 1/68

03824

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <i>Lucretia</i>	Middle <i>O.</i>	Last <i>Shaw</i>	2a. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1968</i>		2b. HOUR <i>11:05</i> AM				
3. SEX <i>F</i>	4. RACE <i>W</i>		5. DATE OF BIRTH <i>6/17/1875</i>		6. AGE (In years last birthday) <i>92</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.					
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shangri La N. H.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Balto. Balto.</i>		13c. CITY OR TOWN <i>21234</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1712 Edgewood Road</i>			
14. FATHER'S NAME First <i>Bryerly</i> Middle <i>H.</i> Last <i>Owens</i>		15. MOTHER'S MA DEN NAME First <i>Elizabeth</i> Middle <i>Blake</i> Last <i>Wales</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-28-0494</i>		17. INFORMANT <i>Mrs. Edith M. Lathroun</i>		Address <i>(Same)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: <i>4339</i> IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)											
19a. DATE OF OPERATION <i>12/14</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>12/14</i> , 19 <i>64</i> , to <i>3/18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3/15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert A. Reiter M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE-SIGNED <i>3/18/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Robert Reiter</i>		22e. ADDRESS <i>606 Edmondson Ave.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 20, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>					
24. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co. 4905 York Road</i>		BALTIMORE, MD. 21212		RECORDED BY REGISTRAR <i>John Judge</i>		REGISTERED BY REGISTRAR <i>John Judge</i>		DATE <i>MAR 19 1968</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 6 Film G398 3/13/68 kk									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
LAYTON			SHIFLETT			Month 3 Day 3 Year 68		11:35 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		CAUCASIAN		8-23 1883		81 8/8 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
VA.		USA				BALTIMORE		CATONSVILLE	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. CITY OR TOWN	
FOREST HAVEN NURSING HOME		LABORER		Unk		MD.		BALTO.	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1133 BONSAI ST.		First Middle Last		First Middle Last	
ROBERT		SHIFLETT		BORINE		MORRIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		216-30-1185		Wm. E. McDonald, 1133 Bonsai St. Balto. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cong. Heart Failure								2 days	
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.CVD								Years	
DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema								Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
5271									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/3/68, 1968 to 3/3/68, 1968, that (I) (we) last saw the deceased alive on 3-3-68 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Ralph E. Updike, M.D.								3/3/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Ralph E. Updike, M.D.				31 Dogwood Drive					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-6-68		Belair Memorial Gardens		Belair, Maryland			
24. FUNERAL DIRECTOR									
John M. Howard 5551 Loch Raven									
RECD BY REGISTRAR DATE MAR 8 1968									
25b. REGISTRAR'S SIGNATURE									
John M. Howard									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 4/1
30M REV 1/68

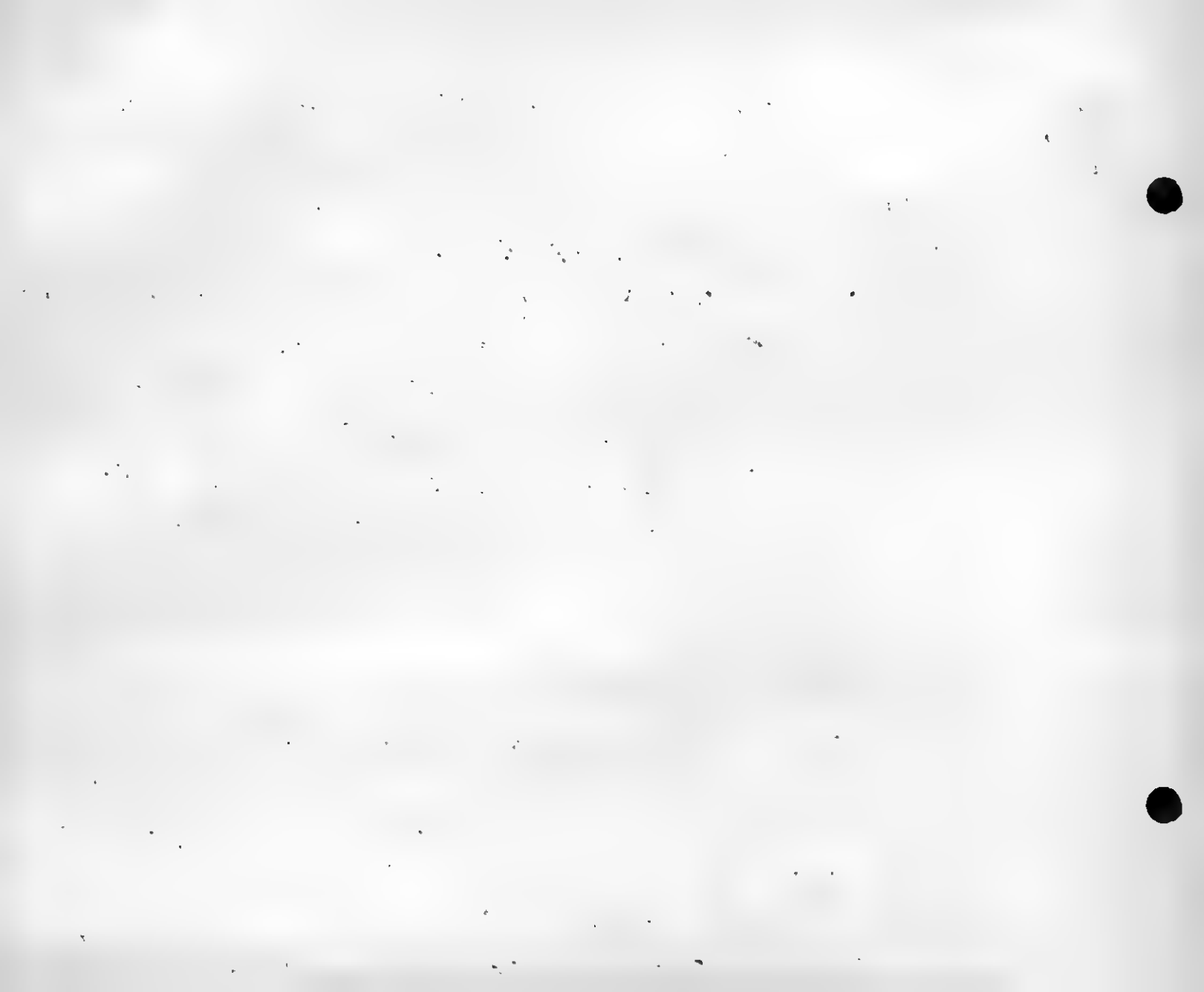
1

03826

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03809

1 DECEASED-NAME (Type or print) First Middle Last KATHERINE E. SIEGMAN			2a. DATE OF DEATH Month Day Year MAR 28 1968		2b HOUR M
3 SEX F	4. RACE W	5 DATE OF BIRTH 7/30/80		6 AGE (In years last birthday) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTO		Md.
10. CITY OR TOWN OF DEATH RURAL		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 628 ROCKAWAY BEACH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RA	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b COUNTY BALTO	13c CITY OR TOWN RURAL	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 628 ROCKAWAY BEACH
14 FATHER'S NAME First Middle Last JOHN LINDENBERGER			15. MOTHER'S MAIDEN NAME First Middle Last MARY EULER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO.	17 INFORMANT F.W. SIEGMAN		Address ABOVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF General. arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) old age + chron. rheum. arthritis (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or RFD No	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from 3/2 , 19 60 , to 3/28 , 19 68 , that (I) (we) last saw the deceased alive on 3/28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dr. John Geldrich		DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 3/30/68	
22d. PHYSICIAN'S NAME (Type) Dr. John Geldrich		22e ADDRESS 3019 Philadelphia Road			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE 4/1/68	23c NAME OF CEMETERY OR CREMATORY BALTO. CEM.		23d LOCATION (City or Town) (County) (State) BALTO. MD.	
24 FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	25a REC'D BY REGISTRAR APR 2 1968	25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

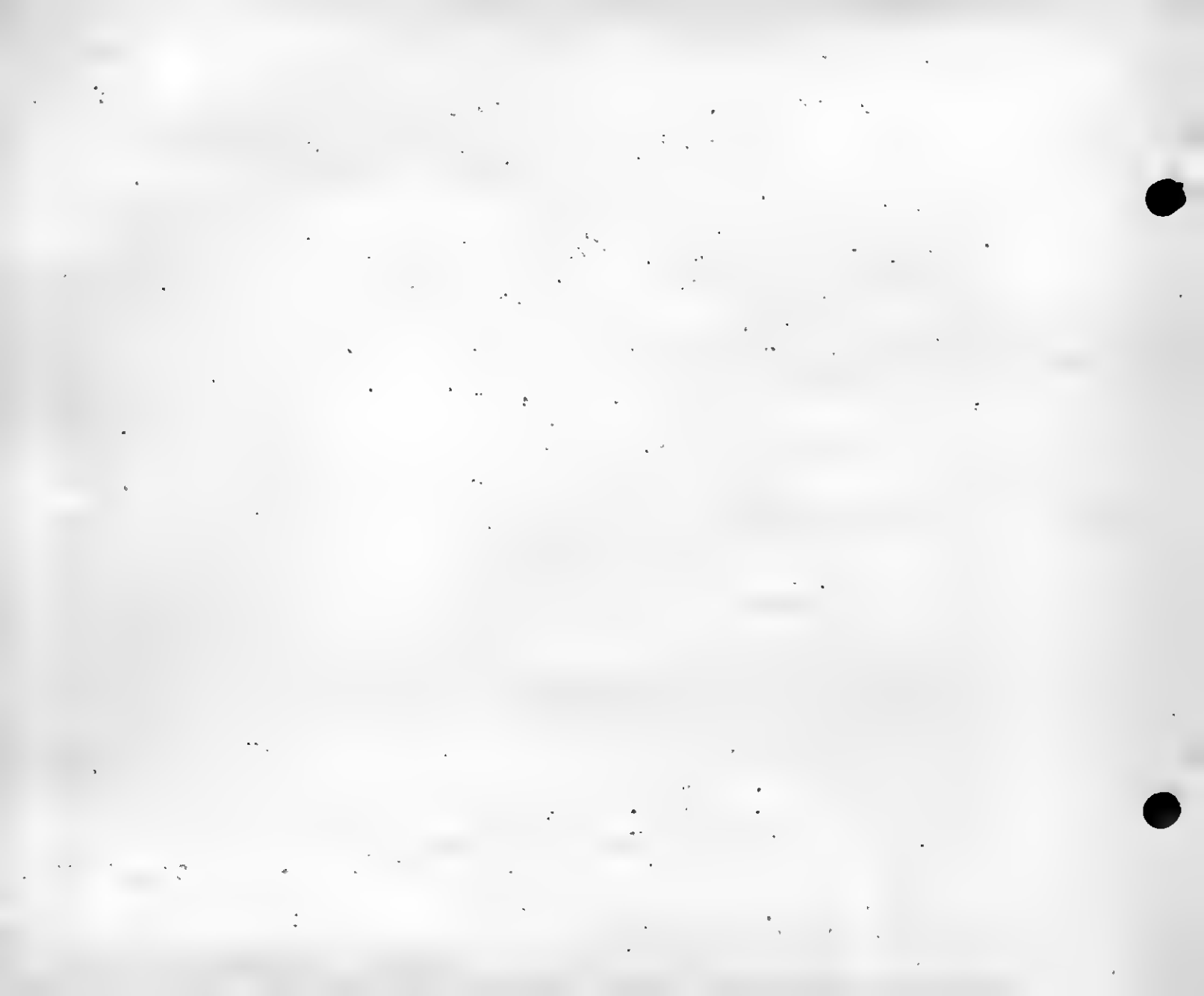
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

038111

1 DECEASED-NAME (Type or print) <i>Alexander</i> First Middle Last			2a. DATE OF DEATH Month <i>3</i> Day <i>23</i> Year <i>68</i>		2b. HOUR <i>11:45 P</i>
3 SEX <i>Male</i>	4 RACE <i>Col</i>	5 DATE OF BIRTH <i>2-18-1900</i>		6 AGE (In years last birthday) <i>68</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore Co.</i> Md.		
10 CITY OR TOWN OF DEATH <i>Catonville Md</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Ridge Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Balto</i>	13c. CITY OR TOWN <i>Balto</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>2561 Harlem Ave</i>	
14 FATHER'S NAME First Middle Last <i>William R Simms</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Roberta Williams</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO.	17 INFORMANT Address <i>Joseph Simms 1700 Mc Culloch St</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pharyngitis Arthritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>years</i> <i>years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4 Diverticulitis with anemia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 67</i> , 19, to <i>March</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3-2-68</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Ralph E. Updike MD</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>23 March 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Ralph E. Updike MD</i>		22e. ADDRESS <i>31 Dogwood Dr. 21043</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-28-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto National Cem</i>	
23d. LOCATION (City or Town) <i>Balto</i>		(County) <i>Md</i>		(State)	
24. FUNERAL DIRECTOR <i>Rayner Sanders</i>		ADDRESS <i>217 E. Preston St</i>		25a. REC'D BY REGISTRAR <i>APR 1 - 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Henry</i>		First	Middle	Last	2a DATE OF DEATH <i>March 26</i>		2b HOUR <i>5:15 PM</i>	
3 SEX <i>M.</i>	RACE <i>W.</i>	5 DATE OF BIRTH <i>Nov 8, 1899</i>		6 AGE (In years last birthday) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) <i>Balto.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTRY OF DEATH <i>Balto.</i>				
10 CITY OR TOWN OF DEATH <i>Balto</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Emmacost Nur Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if just out on Residence before admission) STATE <i>MD</i>	13b COUNTY <i>Balto</i>	13c CITY OR TOWN <i>Balto</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <i>3109 Royston Ave</i>				
14. FATHER'S NAME First <i>John</i> Middle <i>Simon</i> Last		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Julia</i> Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>Yes</i> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <i>213-05-5137</i>		17 INFORMANT <i>WIFE</i>		Address <i>Same</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>165X</i>								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>March, 1967</i> , to <i>March, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 26, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <i>Loy M. Zimmerman M.D.</i>				22c. DATE SIGNED <i>3/27/68</i>		22d. ADDRESS <i>3202 Harford Rd., Baltimore, Md.</i>		
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE <i>3/29/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Balto, Md.</i>		
24. FUNERAL DIRECTOR <i>Ed Cleemann</i>				25a. RECEIVED BY (Name and Address) <i>6067 Harford Rd</i>		25b. RECEIVED BY (Name and Address) <i>John J. Judge</i>		

MAR 29 1968



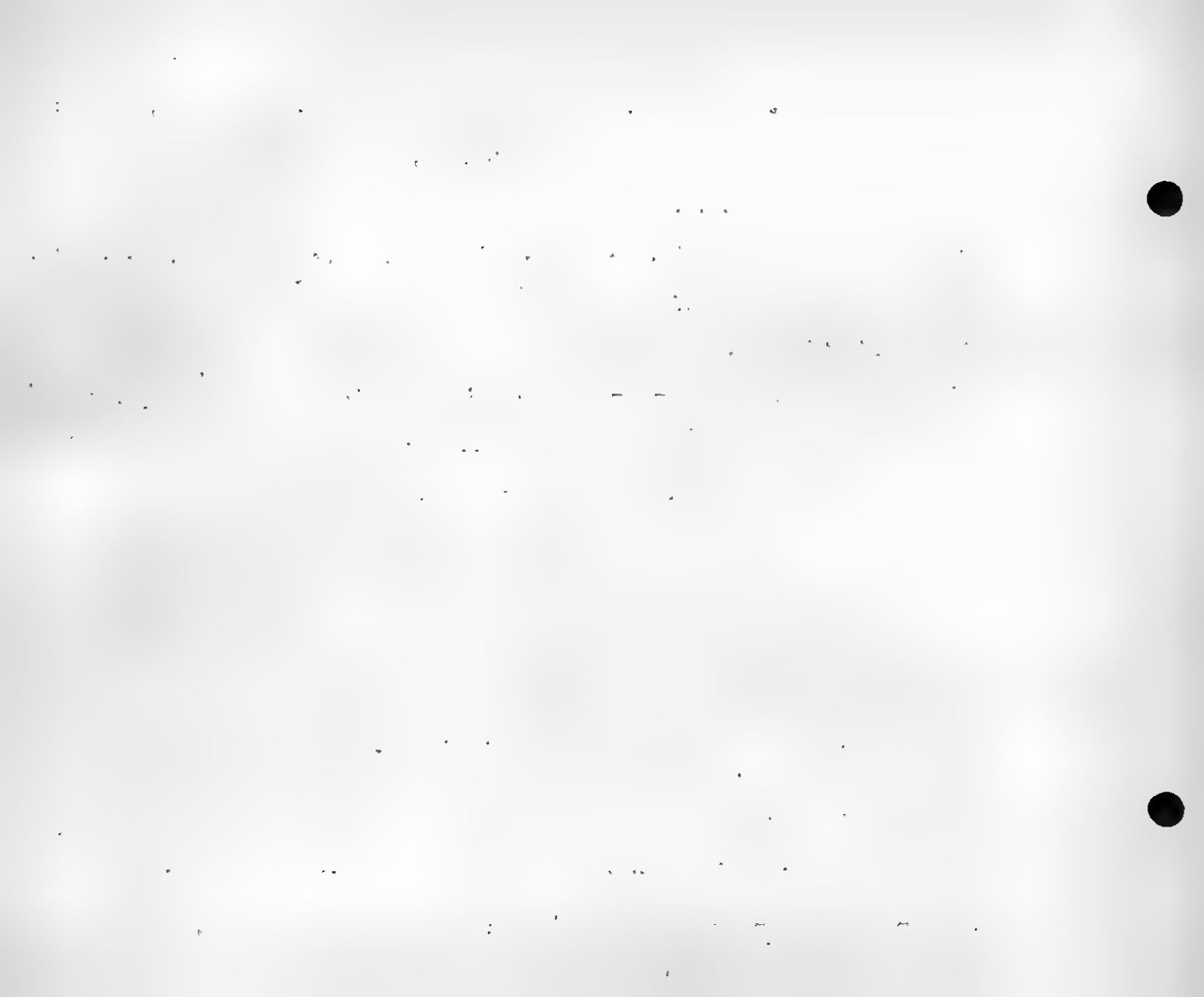
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1 (M)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M				
RICHARD		L.		SIMPIER	MARCH 13, 1968		2:20				
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		JUNE 17, 1930		37 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
WASHINGTON		U.S.A.				BALTIMORE					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
TOWSON		ST. JOSEPH HOSPITAL		NAT. HWY. SAFETY BUR.		U.S. GOV'T.					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
VIRGINIA		FAIRFAX		FAIRFAX				9131 LEGHORN PLACE			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
LAWRENCE M.				SIMPIER	GOLDIE				BEVRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra-cerebral hemorrhage 4309 DUE TO, OR AS A CONSEQUENCE OF (b) rupture of congenital aneurysm of the right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. middle cerebral artery (c)					
YES		KOREAN		538-22-8189		LAURA LEE SIMPIER		9131 LEGHORN PL. FAIRFAX, VIRGINIA			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from MARCH 10 , 19 68 , to MARCH 13 , 19 68 , that (we) last saw the deceased alive on MARCH 13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)						
<i>Ines Cilliani</i>		March 13, 1968			Ines Cilliani, M.D.						
		DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22e. ADDRESS						
					7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
REMOVAL-BURIAL		3-18-68		CHESTNUT GROVE CEMETERY, HERNDON, FAIRFAX, VA.							
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE					
J. Berkley Green		MAR 19 1968		<i>Charles Judge</i>							
GREEN FUNERAL HOME, HERNDON, VIRGINIA											



CERTIFICATE OF DEATH

03813

1. DECEASED NAME (Type or print)			First	Middle	Lost	20. DATE OF DEATH			2b. HOUR		
ADDISON W. SMITH, JR.						March 3, 1968			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
male		caucasian		October 11, 1914		53 YRS		MONTHS DAYS		HOURS MIN	
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash, D.C.		USA				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore Suburban			24 Dowling Circle			salesman			insurance		
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Balto.			Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Addison W. Smith			Louise Chapman			24 Dowling Circle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT					
yes			WW II			Mrs. Addison W. Smith, Jr. - 24 Dowling Circle					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
										2 days	
										2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Dr. William M. Conway						3/4/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Dr. William M. Conway						8358 Loch Raven Blvd.					
230. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3/7/68		Parkwood		Baltimore, Maryland					
24. FUNERAL DIRECTOR						250. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc.-Balto, Md....14						DATE MAR 5 1968		Charles J. Ruck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05831

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03814

1. DECEASED-NAME (Type or print)		First <i>Helen</i>	Middle <i>McDonald</i>	Last <i>Smith</i>	2a. DATE OF DEATH Month <i>March</i> Day <i>20</i> Year <i>1968</i>		2b. HOUR <i>1 P. M.</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>6/19/1921</i>		6. AGE (In years last birthday) <i>46</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>East Orange, N. J.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Lutherville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1023 Adcock Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Pharmacist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Drugs</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Lutherville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Joseph</i> Middle <i>McDonald</i> Last <i>McDonald</i>		15. MOTHER'S MAIDEN NAME First <i>Helen</i> Middle <i>Harris</i> Last <i>Harris</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <i>579-20-6667</i>		17. INFORMANT <i>Richard C. Smith</i>		Address <i>(Same)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i></i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>							
19a. DATE OF OPERATION <i>3-21-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l. medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-19-68</i> , to <i>3/20/1968</i> , that (I) (we) last saw the deceased alive on <i>3-19-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George N. Agapitos</i>		DEGREE <i>Dr. George N. Agapitos</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-21-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Dr. George N. Agapitos</i>		22e. ADDRESS <i>Maryland General Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/23/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Mem. Grds.</i>		23d. LOCATION (City or Town) (County) (State) <i>Timonium, Md.</i>	
24. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co.</i>		ADDRESS <i>4905 York Road Baltimore, Md. 21212</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

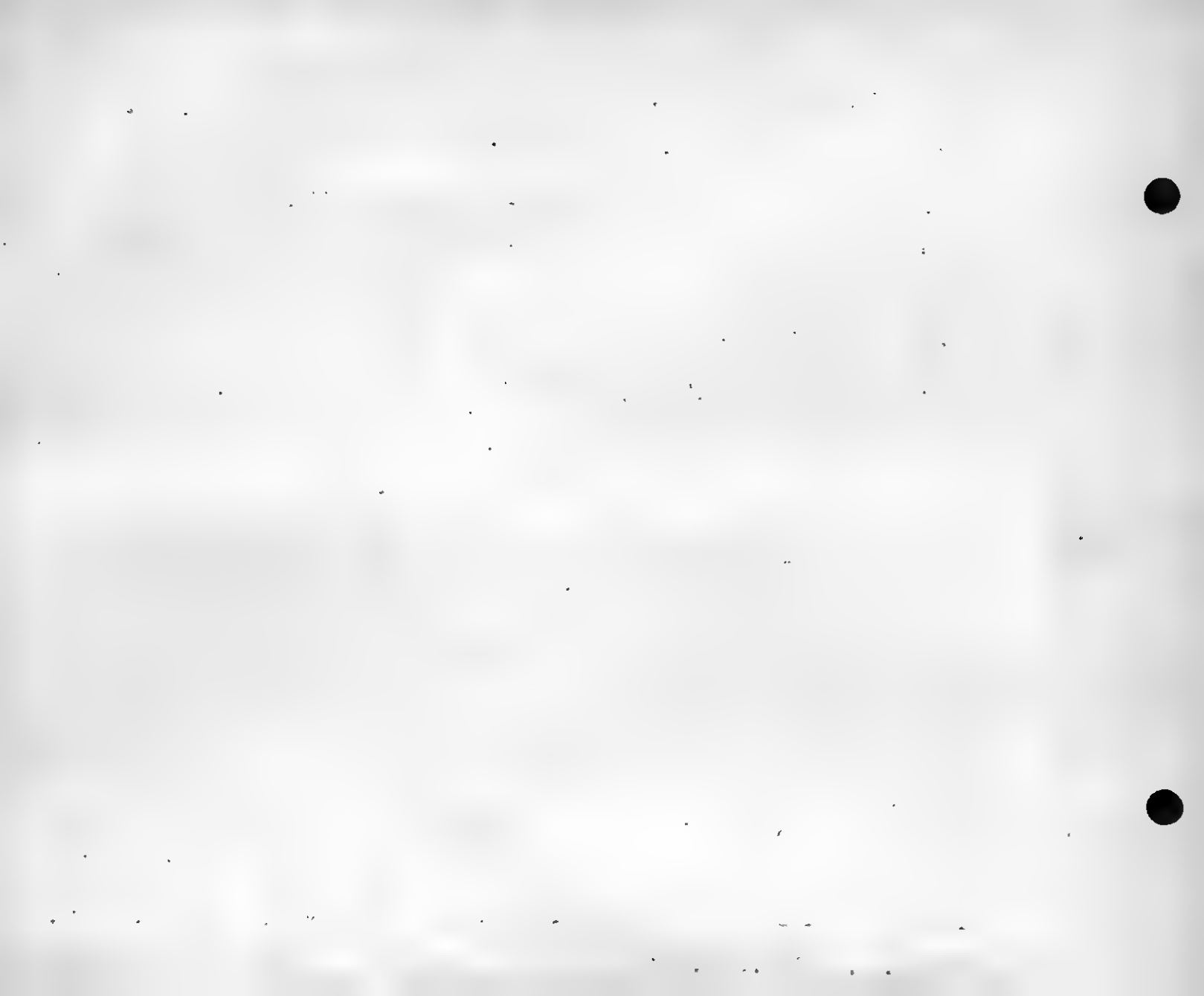
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT5 (4)
30M REV. 1/68

2832
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Joseph A. Smith			2a. DATE OF DEATH Month Day Year 3 4 68			2b. HOUR 9:30 AM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 8-31-94		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltio. Md.			
10. CITY OR TOWN OF DEATH Garrison		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Foxleigh		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Recorder		12b. KIND OF BUSINESS OR INDUSTRY Bath. Steel			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b. COUNTY Baltio		13c. CITY OR TOWN Baltio		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 905 Garden Drive 21221	
14. FATHER'S NAME First Middle Last Louis B. Smith			15. MOTHER'S M.A.DEN NAME First Middle Last Virginia K. Rammings						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Unknown		16b. SOCIAL SECURITY NO 213-09-0606A		17 INFORMANT Address Maynard A. Smith SON Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4367 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days unknown									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized Arterio sclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-2-67 , 19 67 , to 3-4 , 19 68 , that (I) (we) last saw the deceased alive on 3-3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David I. Miller				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-4-68			
22d. PHYSICIAN'S NAME (Type) David I. Miller				22e. ADDRESS Garrison Rd. Owings Mills, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-7-68		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn AA Md.			
24. FUNERAL DIRECTOR Witzke F. D., Balto., Md. 21229				25a. REC'D BY REGISTRAR MAN 5 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME150
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

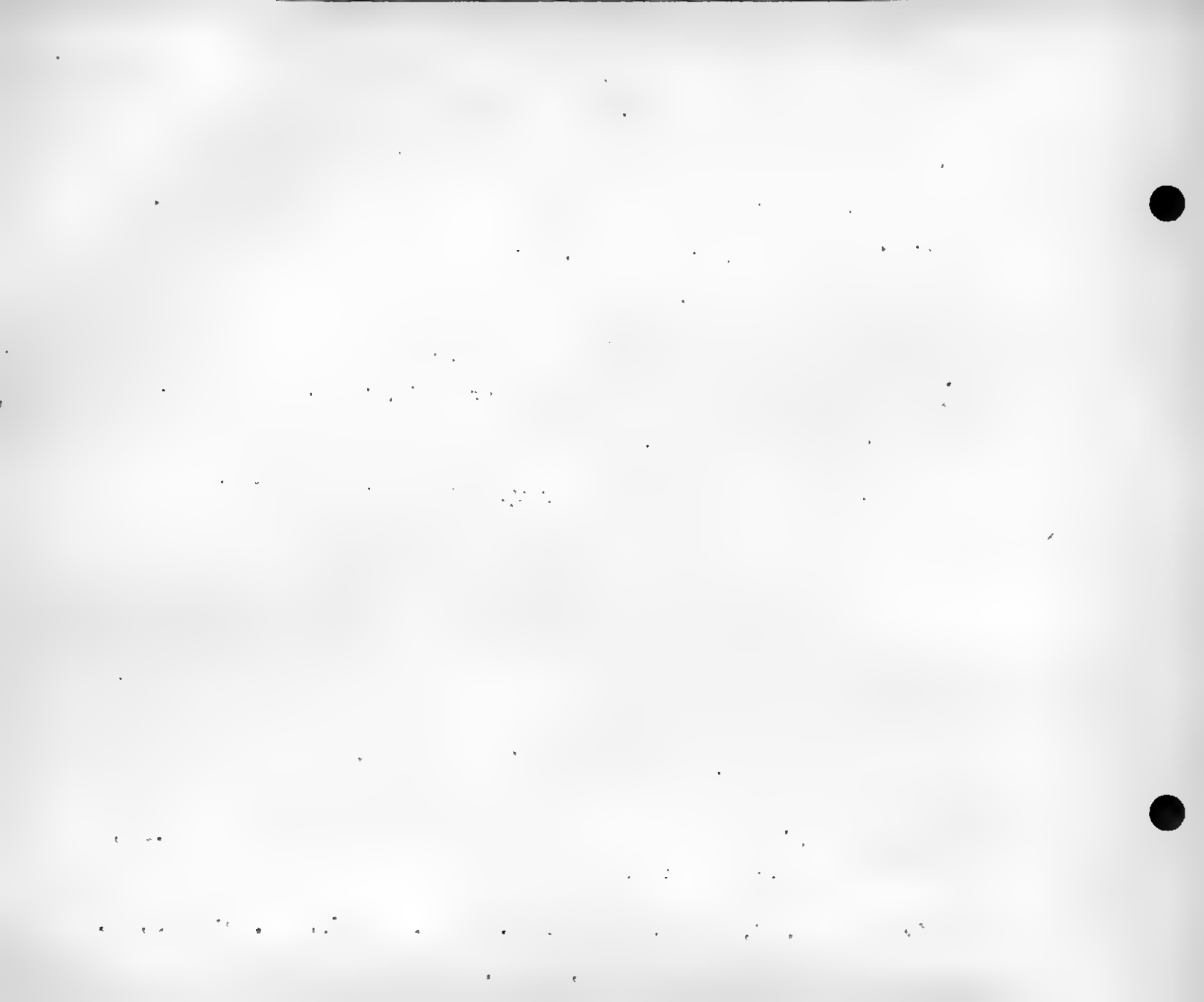
1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOUR
Russell, Smith Smith					3/4/68		19			1:45
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS		8 IF UNDER 24 HRS HOURS		9 IF UNDER 24 HRS MIN	
M	N	8/18/15		52 YRS						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MDA						Baltimore				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Baltimore		Balto. Cnty. Gen. Hosp.				Chauffeur				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.				Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		177		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Robert				Smith	Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
				215-10-0570		Spouse-Eunice Smith		413 Denison St.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u>										<u>Minutes</u>
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4109										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		HOUR A.M. P.M. 19								
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		J. Nelson McKay		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		J. Nelson McKay				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		March 4, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		3-9-68		Arlington Memorial		Baltimore		MD.		
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Arlington		172 N. Monmouth		DATE MAR 12 1968		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove card and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-14
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) First Middle Last JOHN MELVIN SMOOT					2a. DATE OF DEATH 3 Month 9 Day 68 Year		2b. HOUR 6:30 P.M.			
3. SEX M		4. RACE W		5. DATE OF BIRTH 7-10-10		6. AGE (in years last birthday) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Mount Wilson, Maryland Md.				
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) JANITOR		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN WHITEFORD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last PERRY			15. MOTHER'S MAIDEN NAME First Middle Last SMOOT LAURA RENKER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) No		16b. SOCIAL SECURITY NO. 214-12-2265		17. INFORMANT Address Records, Mt. Wilson State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>COR PULMONALE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>5771 POLYCYTHEMIA</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV. 26, 1967</u> to <u>MARCH 9, 1968</u> ; that (I) (we) lost the deceased alive on <u>MARCH 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William Newcomer</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Mar. 10, 1968			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.					22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gdns.		23d. LOCATION (City or Town) (County) (State) Aldino, Harford, Md.				
24. FUNERAL DIRECTOR <u>John H. Harbina</u>					ADDRESS Delta, Penna.		25a. REC'D BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03835

03818

1. DECEASED NAME (Type or print) L MIDDLE CARROLL LAST SNYDER			2a. DATE OF DEATH MARCH Month 12 Day, 1968 Year			2b. HOUR P 10:50 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MAY 10, 1912		6. AGE (In years lost birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY BENDIX RADIO	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY Balto.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5944 CLAYTON AVE. #21206	
14. FATHER'S NAME First Jacob Middle Snyder Last			15. MOTHER'S MAIDEN NAME First Mary Middle Dawson Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-05-8127		17. INFORMANT Address A. Regina Snyder-5944 Clayton Avenue-21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS 1950 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION 11/11		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from MARCH 2 , 19 68 , to MARCH 12 , 19 68 , that he (we) lost the deceased alive on MARCH 12 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.									
22b. SIGNATURE Lope T. Villa Jr. M.D.				22c. DATE SIGNED MARCH 13, 1968					
22d. PHYSICIAN'S NAME (Type) LOPE VILLA, JR., M.D.				22e. ADDRESS 7620 YORK ROAD TOWSON, MD. #21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-15-68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206				25a. REC'D BY REGISTRAR MAR 18 1968		25b. REGISTRAR'S SIGNATURE John C. Miller			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A1541
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last ANNA ANNIE SOLOMON			2a. DATE OF DEATH Month Day Year MARCH 24, 1968		2b. HOUR 5:30 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 18, 1887		6. AGE (In years last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7909 SUBET ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3915 EMMART AVENUE
14. FATHER'S NAME First Middle Last MORRIS LEVY		15. MOTHER'S MAIDEN NAME First Middle Last RACHEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. RUTH BROWN, 7909 SUBET ROAD #21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 450.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/24, 1950</u> , to <u>3/24, 1968</u> , that (I) (we) last saw the deceased alive on <u>3/24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Nathan E. Needle M.D.</u>		22c. DATE SIGNED <u>3/24/68</u>		22d. PHYSICIAN'S NAME (Type) NATHAN NEEDLE	
22e. ADDRESS 6506 PARK HEIGHTS AVENUE		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-26-68		23c. NAME OF CEMETERY OR CREMATORY OHEL YAKOV	
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		23e. REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN ROAD, BALTO. 21215					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 7/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
CERTIFICATE OF DEATH																		
1. DECEASED NAME (Type or print)			First <i>ELENNORA</i>			Middle <i>A</i>			Last <i>SPIEKER</i>			2a. DATE OF DEATH 3 Month 6 Day 68 ^{ear}			2b. HOUR 9:35 AM			
3 SEX <i>F</i>			4. RACE <i>W</i>			5. DATE OF BIRTH <i>Feb. 24, 1902</i>			6. AGE (In years last birthday) 66 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>BAIT.</i>									
10. CITY OR TOWN OF DEATH <i>CATONSVILLE</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>48 Glenwood Ave</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>BAIT.</i>			13c. CITY OR TOWN <i>CATONSVILLE</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <i>48 Glenwood Ave</i>						
14. FATHER'S NAME First <i>FREDERICK</i>			Middle <i>C.</i>			Last <i>DILL</i>			15. MOTHER'S MAIDEN NAME First <i>MARGARET</i>			Middle <i>(UNKNOWN)</i>			Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <i>ELENNOR H. GREEN 48 Glenwood Ave</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARCINOMA OF COLON</i> <i>1968</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 YRS.</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION <i>1964</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>RESECTION OF BOWEL</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from <i>FEB 29, 1960</i> , to <i>MAR 6, 1968</i> , that (I) (we) last saw the deceased alive on <i>FEB 27, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>John N. Snyder</i>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>3/7/68</i>									
22d. PHYSICIAN'S NAME (Type) <i>JOHN N. SNYDER</i>			22e. ADDRESS <i>6348 FREDERICK RD CATONSVILLE MD 21228</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>3/9/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>LOUDON PK. CEM</i>			23d. LOCATION (City or Town) (County) (State) <i>BAIT. Md</i>									
24. FUNERAL DIRECTOR <i>E. B. Mac Nab</i>			ADDRESS <i>Catonville Md.</i>			25a. REC'D BY REGISTRAR <i>MAR 11 1968</i>			25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>									

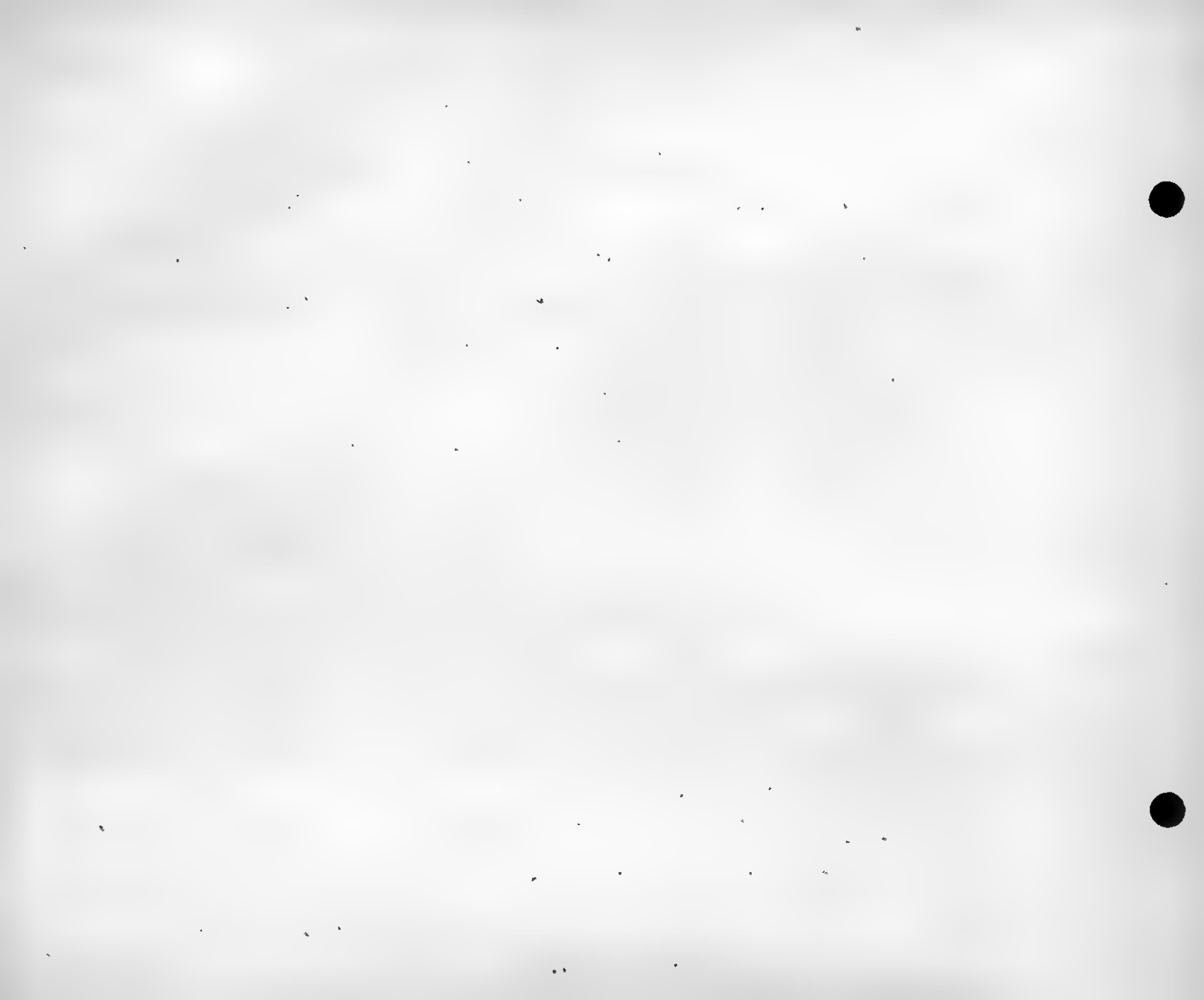


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print) First Middle Last ALFIO PETER SPINNIOCHIO			2a DATE OF DEATH Month Day Year 3 18 68			2b HOUR 430 A M								
3 SEX Male		4 RACE Italian White		5 DATE OF BIRTH 7/9/82		6 AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN						
7a BIRTHPLACE (State or foreign country) Sicily, Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.								
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired boiler maker		12b. KIND OF BUSINESS OR INDUSTRY B+O RR.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN OVERLEA		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7011 Beech Avenue						
14. FATHER'S NAME First Middle Last Ciro Spinniochio			15 MOTHER'S MAIDEN NAME First Middle Last Santina Malia											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 705-03-6029		17 INFORMANT Address Records; Spring Grove State Hospital										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4.5</u>														
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>64</u> , to <u>3/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <u>Sherwood E. Wilson, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c DATE SIGNED <u>3/18/68</u>									
22d. PHYSICIAN'S NAME (Type) Sherwood E. Wilson, M.D.					22e ADDRESS Spring Grove State Hospital									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)								
<u>BURIAL</u>		<u>MAR 21, 1968</u>		<u>HOLY REDEEMER CEM</u>		<u>BALTO MD.</u>								
24 FUNERAL DIRECTOR <u>DIPPEL BRO'S INC.</u>					25a. REG. D BY REGISTRAR <u>MAN 20 1968</u>					25b REGISTRAR'S SIGNATURE <u>[Signature]</u>				
ADDRESS <u>7110 BELAIR RD</u>					DATE									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

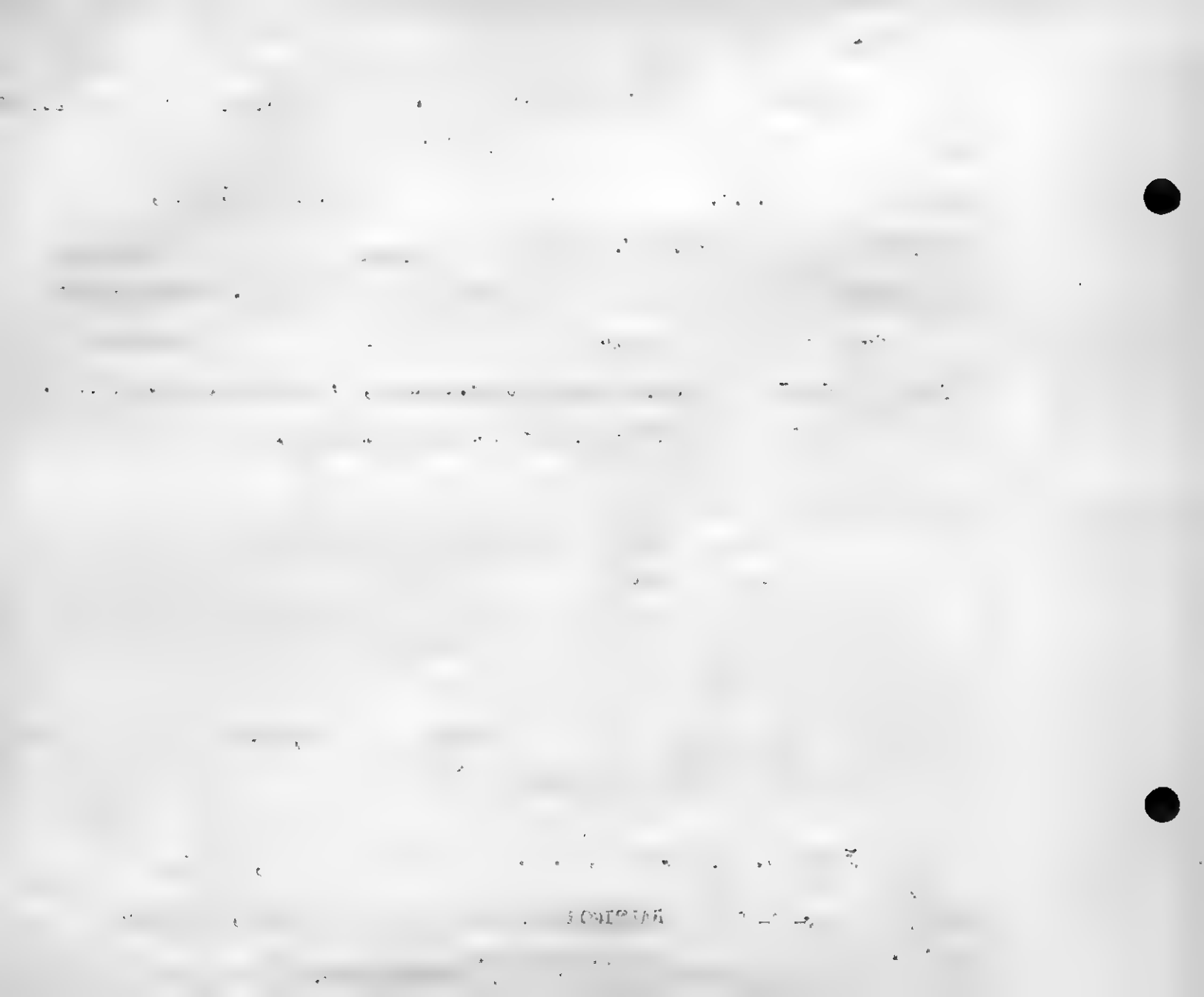
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VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First WILLIAM	Middle JOSEPH	Last SPROLE SR.	2a. DATE OF DEATH Month MARCH Day 18 Year '68		2b. HOUR 1200NOON					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/25/04		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS IF UNDER 72 HRS HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY,			Md			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SEAMAN,		12b. KIND OF BUSINESS OR INDUSTRY SHIPPING						
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2104 E. Lombard Street				
14. FATHER'S NAME First Harry		Middle Sprole		Last Anna		15. MOTHER'S MAIDEN NAME First Anna		Middle Costello		Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO 011 18 49 86		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE LEFT MIDDLE CEREBRAL ARTERY 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CARCINOMA COLON, SIGMOID												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from 1/30/68 , 19____, to 3/18/68 , 19____, that (X) (we) last saw the deceased alive on 3/18/68 , 19____, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>George C. McElPatrick</i>		DEGREE MD			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/18/68					
22d. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Mar-21-1968		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County)		(State)		
24. FUNERAL DIRECTOR John J. Duda		ADDRESS DUDA FUNERAL HOME			25a. RECEIVED BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>John J. Duda</i>					
ADDRESS HUDSON STREET, BALTIMORE, MD.												



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) GEORGE LEONARD STACHNICK			2a. DATE KNOWN OF DEATH Month 3 Day 12 Year 1968			2b. HOUR 2A M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MAY 7 1902	6. AGE (In years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS — DAYS —	IF UNDER 24 HRS HOURS — MIN —	2c. DATE PRONOUNCED DEAD Month 3 Day 12 Year 1968		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 2913 ANDORA CT.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) COMMERCIAL ARTIST		12b. KIND OF BUSINESS OR INDUSTRY AIRPLANE		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2913 Andora Court.
14. FATHER'S NAME First John Middle Stachnick Last Stachnick			15. MOTHER'S MAIDEN NAME First Catherine Middle Siles Last Siles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) no		16b. SOCIAL SECURITY NO. 176 01 1017		17. INFORMANT Margaret J. Stachnick		ADDRESS 2913 Andora		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aneurysm Abdominal DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Thrombotic Infarct								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-8 hr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Coronary Thrombotic Infarct			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year — P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No — City or Town — County — State —				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE F.T. KASIK, JR.		EXAMINER'S NAME (Type) F.T. KASIK, JR.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/12/68 ADDRESS (Street, city, town, or county) 9005 HARTFORD Rd.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



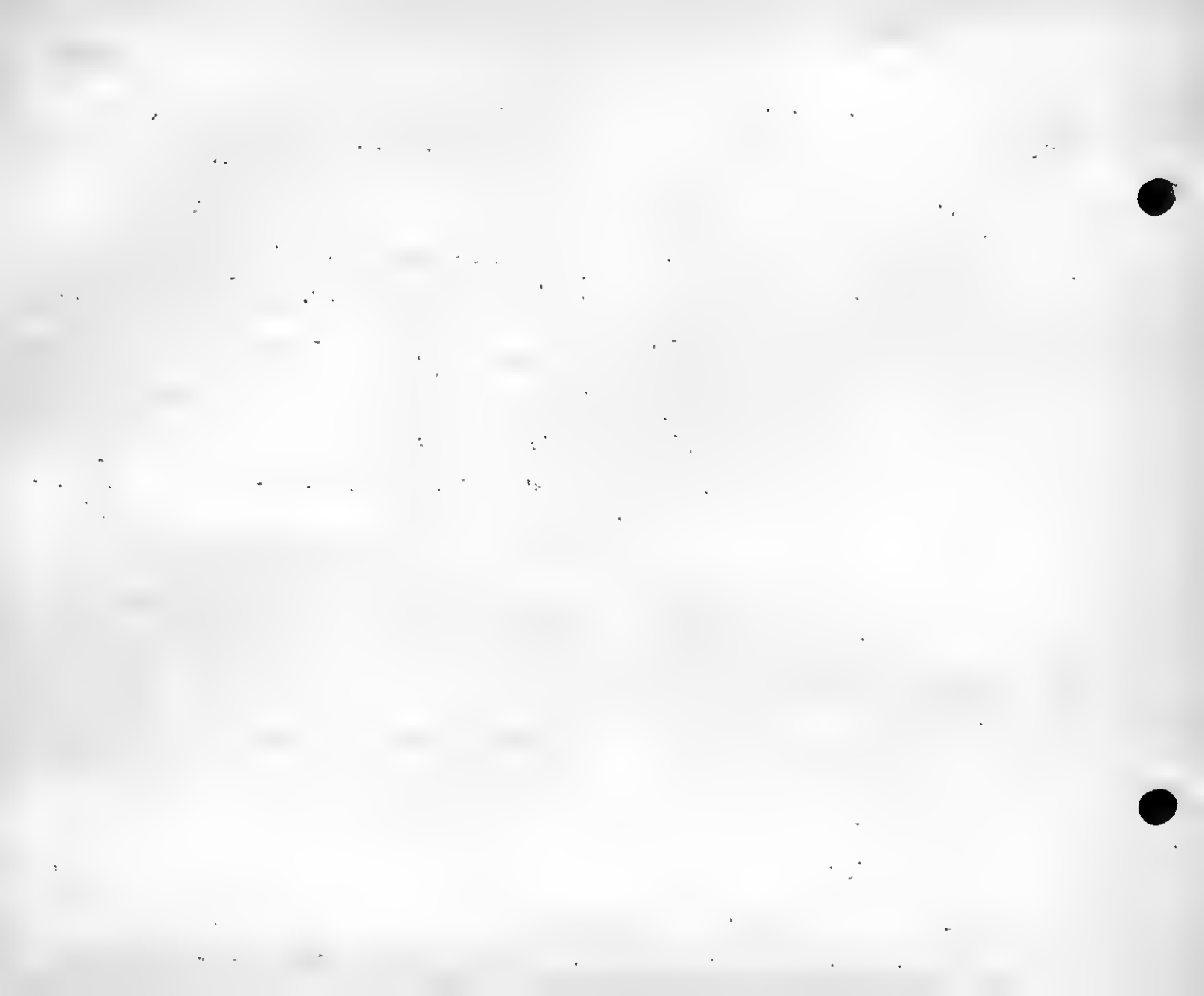
CERTIFICATE OF DEATH

03824

1. DECEASED NAME (Type or print) First: <u>Albert</u> Middle: <u>Stahl</u> Last: <u>Stahl</u>		2a. DATE OF DEATH 3 Month 26 Day 68 Year		2b. HOUR 2:30 PM
3. SEX <u>Male</u>	4. RACE <u>CAU</u>	5. DATE OF BIRTH <u>12/21/02</u>		6. AGE (In years last birthday) 65 YRS.
7a. BIRTHPLACE (State or foreign country) <u>Balt. Md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH <u>Baltimore</u>		10. CITY OR TOWN OF DEATH <u>Baltimore</u>		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Greater Baltimore Medical Center</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE <u>md</u>		13b. COUNTY <u>Baltimore</u>		13c. STREET AND NUMBER <u>2806 Delmont Ave</u>
14. FATHER'S NAME First: <u>Lawrence</u> Middle: <u>Stahl</u> Last: <u>Stahl</u>		15. MOTHER'S MAIDEN NAME First: <u>XXXX</u> Middle: <u>Unknown</u> Last: <u>Unknown</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO <u>215-10-6913</u>		17. INFORMANT <u>Patient's Chart</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Basilar Carotid artery stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 years</u> <u>15-20 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION <u>3/21/68</u> <u>3/23/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Stenosis of left internal carotid</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>March 17, 1968</u> to <u>March 26, 1968</u> , that (I) (we) last saw the deceased alive on <u>3-26-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Tom Poliness MD</u>		22c. DATE SIGNED <u>3-26-68</u>		22d. PHYSICIAN'S NAME (Type) <u>TOM POLINESS</u>
22e. ADDRESS <u>GBMC, 6701 N. CHARLES ST, 21204</u>		22f. ADDRESS <u>GBMC, 6701 N. CHARLES ST, 21204</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-30-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Howard County, Maryland</u>		23e. LOCATION (City or Town) (County) (State) <u>Howard County, Maryland</u>		
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR DATE <u>APR 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



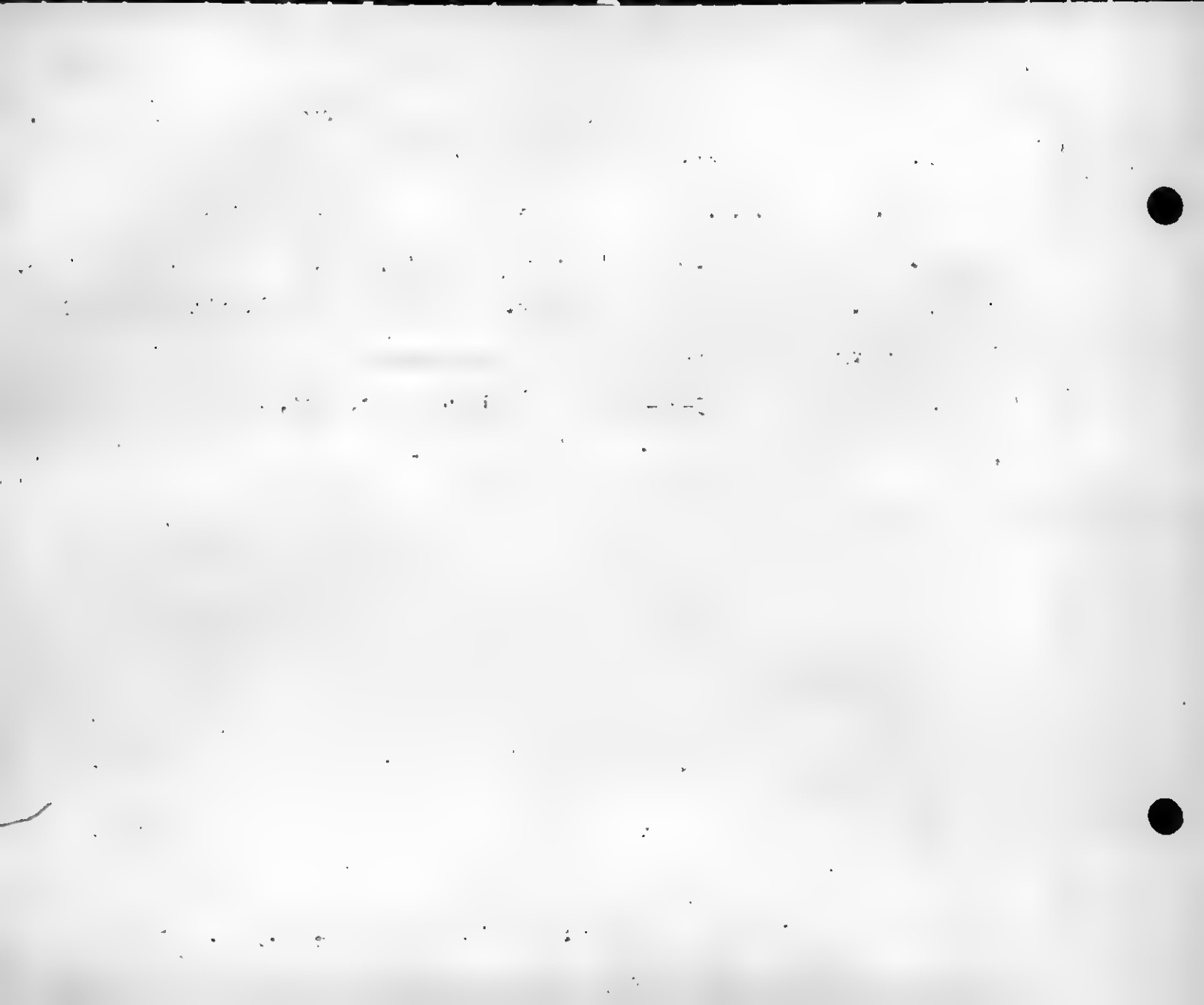
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and send them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03825

1. DECEASED-NAME (Type or print) Frank Henry Stallman			2a. DATE OF DEATH March Month 15 Day 19 Year 68			2b. HOUR 124 A.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH 10/18/78		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Catonsville, Baltimore Md.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Meat Packer		12b. KIND OF BUSINESS OR INDUSTRY Cork Hill & Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3024 Mayfield Avenue 21213	
14. FATHER'S NAME First Henry Middle Stallman Last Stallman			15. MOTHER'S MAIDEN NAME First Josephine Middle Wilkie Last Wilkie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 215-09-9735		17. INFORMANT Marie Langhirt, dhgt, above		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 1964 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7815									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8 Jan, 1968 , to 15 Mar 1968 , that (I) (we) last saw the deceased alive on 14 Mar 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William Goodman, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 15 Mar 68	
22d. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN, M.D.				22e. ADDRESS 1334 SULPHUR SPRING ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/18/68		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Balto., Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane 21213				25a. REC'D BY REGISTRAR DATE MAR 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

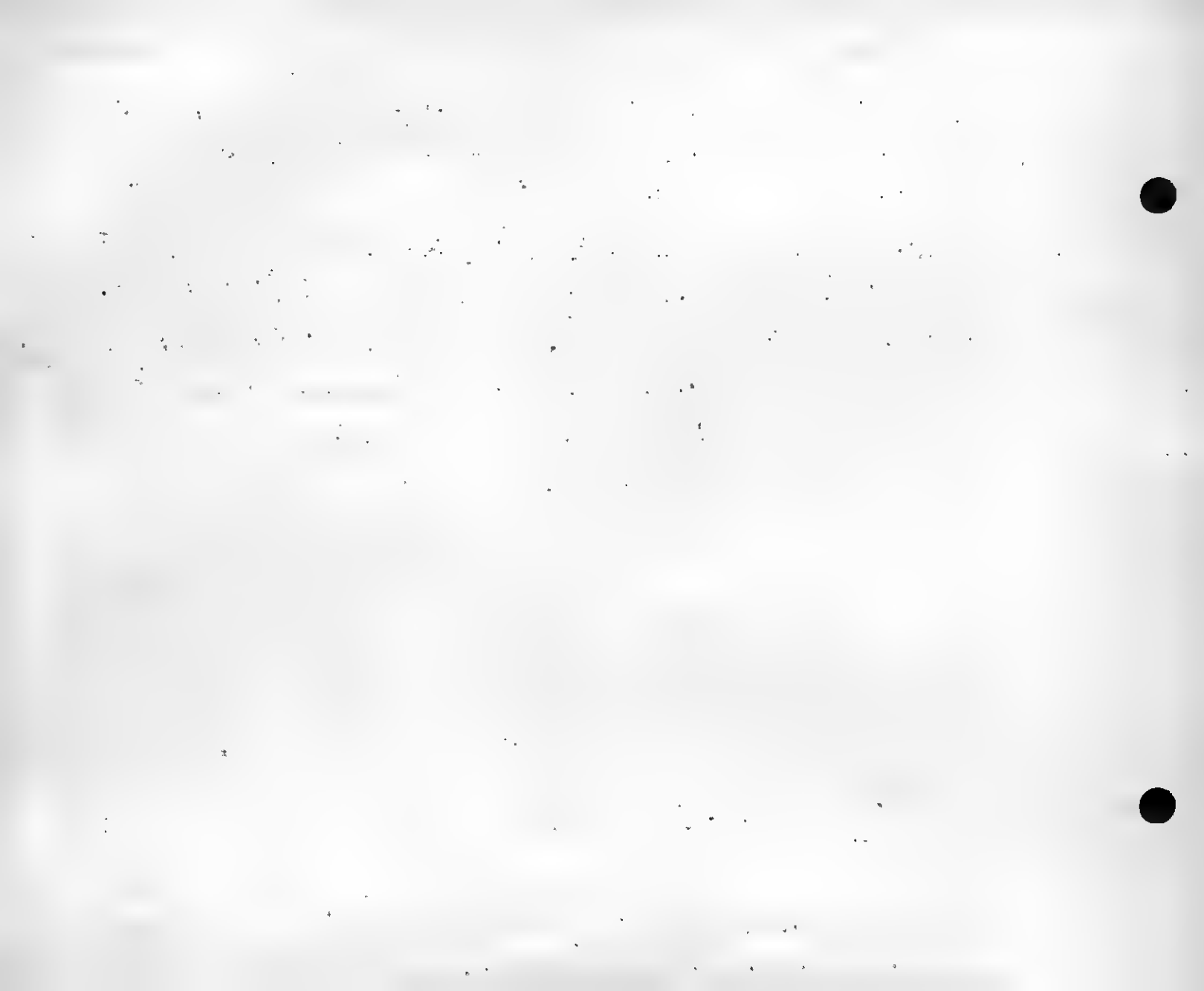


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last THOMAS FRANCIS STEVENS JR.			2a. DATE OF DEATH Month Day Year 3 17 68			2b. HOUR 7 P M	
3 SEX male		4. RACE cau		5. DATE OF BIRTH 2 - 8 - 18		6. AGE (In years lost birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) Balto Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Balto md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Security coordinator		12b. KIND OF BUSINESS OR INDUSTRY Brnd. & Radio	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE md		13b. COUNTY Balto		13c. CITY OR TOWN Towson		13d. INSIDE CITY 10115? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 801 Hillen Rd 21204							
14. FATHER'S NAME First Middle Last Dr Thomas F. A. Stevens			15. MOTHER'S MAIDEN NAME First Middle Last Charlotte E. TAUBER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes WW 2		16b. SOCIAL SECURITY NO 214-14-5598		17. INFORMANT Edith M. Stevens (wife)		Address Same as patient	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial Infarction. 412.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/17, 1968 to 3/17, 1968 , that (I) (we) last saw the deceased alive on 3/17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Derek A. Bruce M.D.		DEGREE DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/18/68	
22d. PHYSICIAN'S NAME (Type) DEREK A. BRUCE		22e. ADDRESS G. B. M. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.				25a. REC'D BY REGISTRAR MAR 21 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Charles F. T. Stiffler</i>			2a. DATE OF DEATH <i>March 30, 1968</i>			2b. HOUR <i>2:00 P.M.</i>		
3 SEX <i>Male</i>			4 RACE <i>White</i>			5. DATE OF BIRTH <i>Dec. 26, 1888</i>		
7a. BIRTHPLACE (State or foreign country) <i>Beckleysville Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <i>Freeland</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>New Freedom Rd.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Foreman</i>		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Baltimore</i>			13c. INS. OF CITY LIM. TST? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>John W. Stiffler</i>			15. MOTHER'S MAIDEN NAME First <i>Joanna</i>			16. ADDRESS <i>Freeland Md.</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>198-10-4346</i>			17. INFORMANT <i>Lola Stiffler</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 10, 1954</i> , to <i>Mar. 30, 1968</i> , that (I) (we) last saw the deceased alive on <i>Mar. 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Richard Robinson, M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>4-1-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Dr. Richard Robinson</i>						22e. ADDRESS <i>New Freedom, Pa.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>April 3, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Abraham's Cem.</i>		
24. FUNERAL DIRECTOR <i>Isaac Hartenstein</i>			ADDRESS <i>New Freedom, Pa.</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>		
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
						DATE <i>APR 4 - 1968</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
OR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

103845

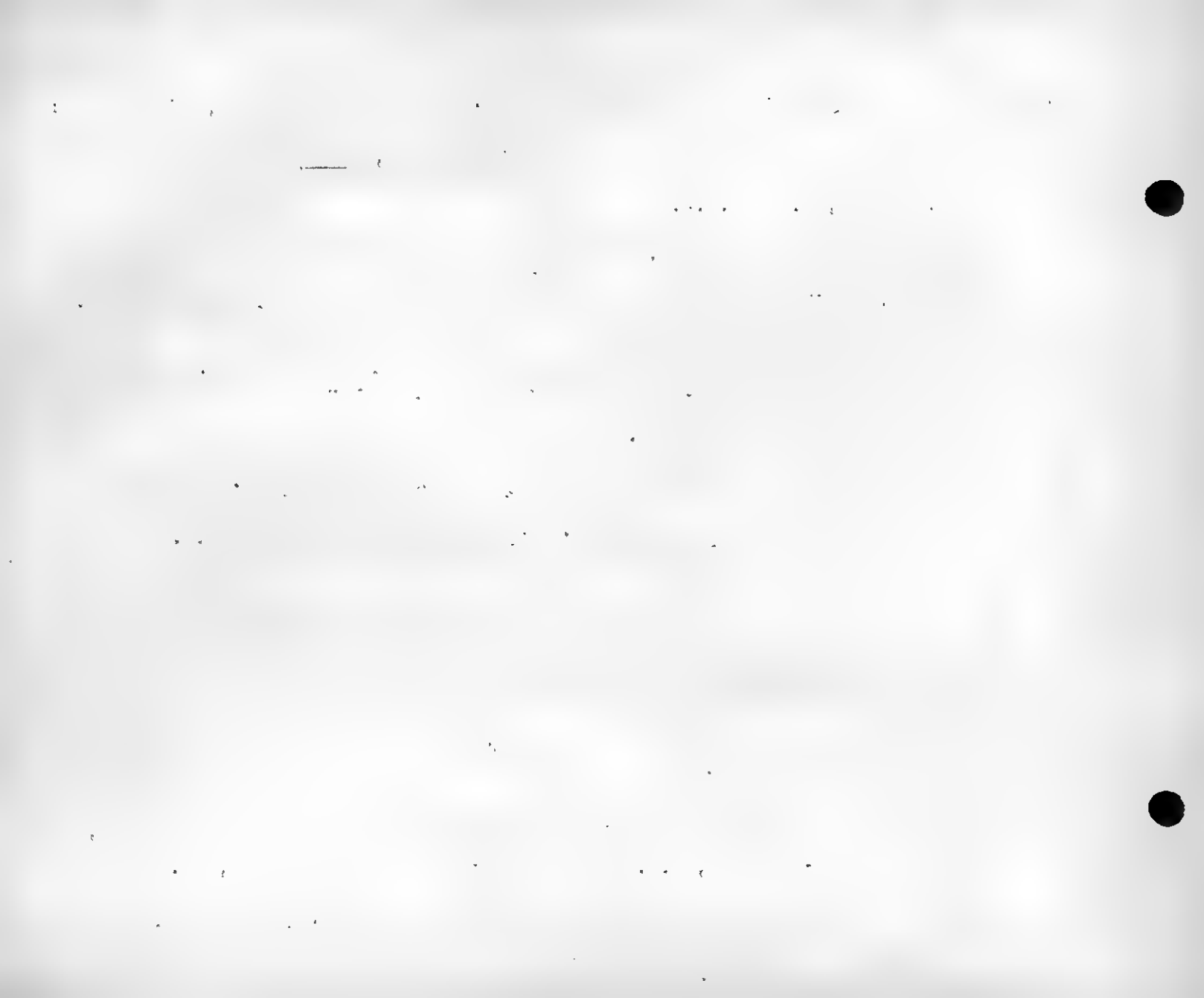
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>3 DA.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMACOST NURSING HOME</u>				d. STREET ADDRESS <u>6216 PINEHURST RD - 12</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>B.</u> Last <u>STINEBERT</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1968</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 25, 1889</u>	9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	IF UNDER 24 HRS Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DENTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BERNARD STINEBERT</u>				14. MOTHER'S MAIDEN NAME <u>ELLA HOSES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-38-2205A</u>		17. INFORMANT <u>EDW. R. STINEBERT, D.D.S.</u>		Address <u>305 TUNBRIDGE RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 4137 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> 19 <u>66</u> to <u>3-31</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-31</u> 19 <u>68</u> , and that death occurred <u>at home</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank G. KUETHN</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type or print) <u>FRANK G. KUETHN</u>				22d. ADDRESS <u>Med Arts Bldg 721 Balto Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/1/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mitchell-Wiedefeld Home</u> <u>6500 York Road-21212</u>				25a. REC'D BY REGISTRAR DATE <u>APR 5 - 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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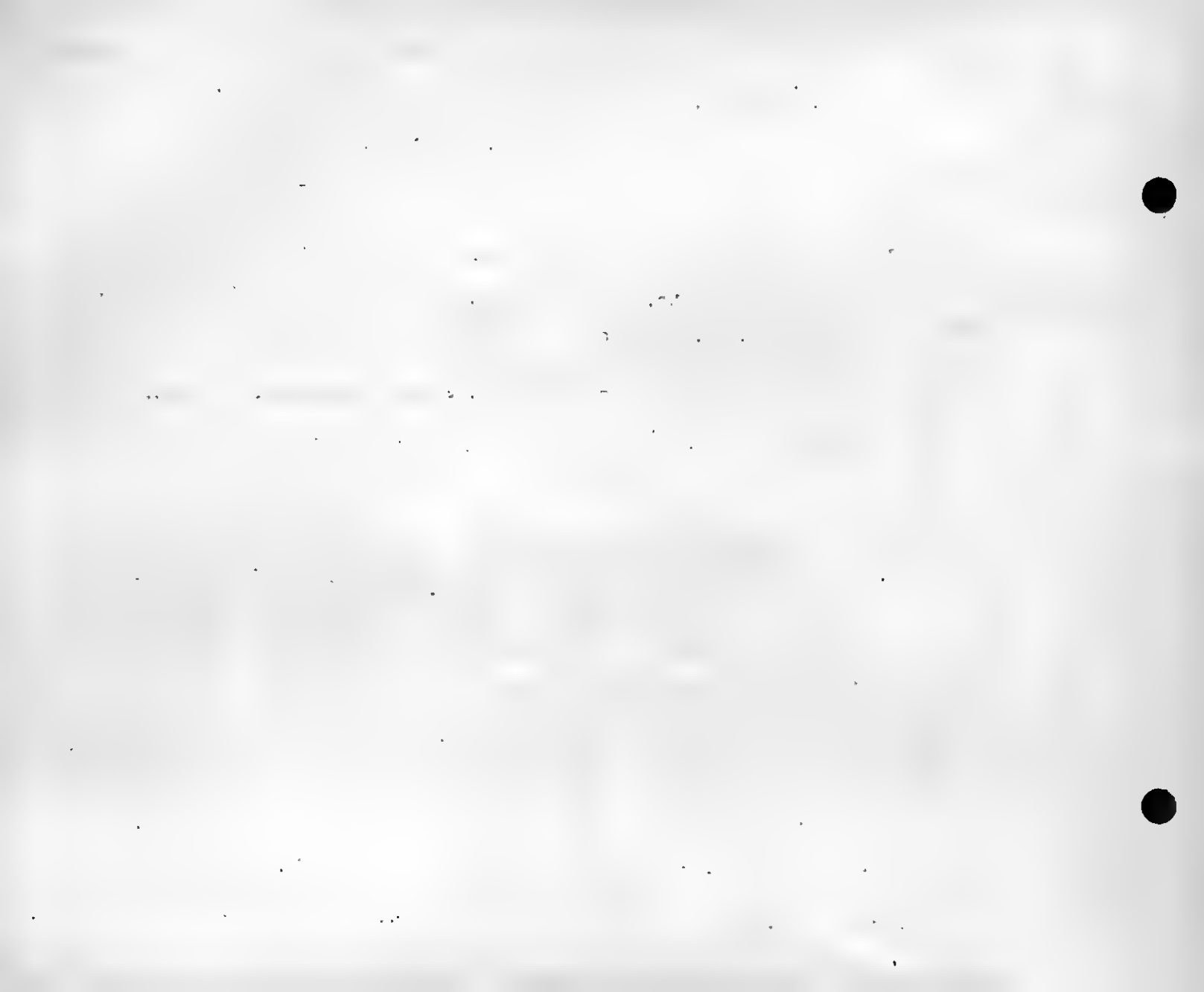
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First LILLIAN Middle MAE Last STITCHER					2a. DATE OF DEATH Month MARCH Day 17 , 1968 Year			2b. HOUR 4:50 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 20, 1892		6. AGE (In years last birthday) 75 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housekeeper-			12b. KIND OF BUSINESS OR INDUSTRY Mrs. Weaver	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4222 LOCH RAVEN BLVD. 21218	
14. FATHER'S NAME First William P. Middle Stitcher Last				15. MOTHER'S MAIDEN NAME First Mandella Middle Parrish Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO 212-05-8790A		17. INFORMANT 502 N. Linwood Ave Milton P. Stitcher, brother					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE w/BILATERAL PLEURAL EFFUSION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERISCLEROTIC CARDIOVASCULAR DISEASE -OLD M.I.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 16 , 1968, to MARCH 17 , 1968, that (I) (we) last saw the deceased alive on MARCH 17 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jaime Singzon, M.D.				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED MARCH 17, 1968	
22d. PHYSICIAN'S NAME (Type) JAIME SINGZON, M.D.		22e. ADDRESS 7620 YORK ROAD TOWSON, MD. #21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/20/68		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				ADDRESS 2601 E. Madison St.		25a. REC'D BY REGISTRAR MAR 19 1968		25b. REGISTRAR'S SIGNATURE	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) VELMA K. STOREY					2a. DATE OF DEATH Month 3 Day 21 Year 68		2b. HOUR 5 A M		
3 SEX F		4 RACE W		5. DATE OF BIRTH 10 14-2-10		6. AGE (in years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shangri La Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Balto.		13c CITY OR TOWN Halethorpe		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 1806 Woodside Ave. 21227	
14. FATHER'S NAME First Frederick Middle x H. Last German				15 MOTHER'S MAIDEN NAME First Elizabeth Middle Krineckie Last Krineckie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. - - - -		17. INFORMANT Address John W. Storey, 1806 Woodside Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal liposarcoma with DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Metastases DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Paraplegia - Urinary Infection - Anemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-8-1967 to 3-21-1968 , that (I) (we) lost saw the deceased alive on 3-21-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Cesar Valle Cervero				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-21-68			
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO				22e. ADDRESS 2629 Liberty Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/25/68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



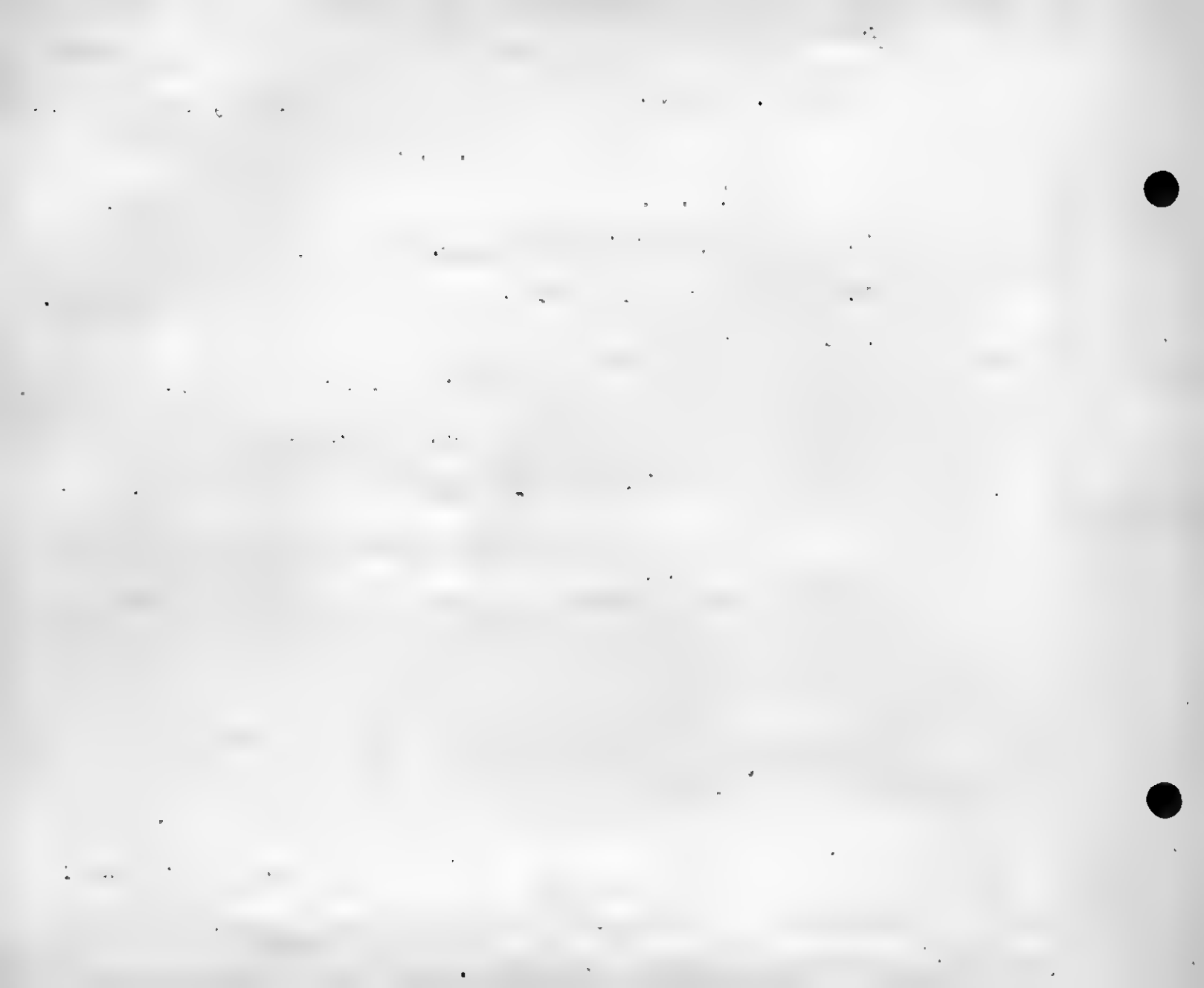
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VR A15 (4)
30M REV. 1/68

3845 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First Middle Last		2a DATE OF DEATH		2b HOUR	
Ella E. Strohmer				March 5, 1968		12:30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)	
Female		White		Jan. 8, 1876		92 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
		U. S. A.				Baltimore County Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		Shangri-La-333HarlemLa.		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Baltimore		Baltimore		2127 Old Frederick Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO	
First Middle Last		First Middle Last		no		---	
Adolph Driescher		Lena ?					
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?	
Address		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro Vascular accident</u>		3/1/68		YES <input type="checkbox"/> NO <input type="checkbox"/>	
Mr Arthur F. Strohmer 2127 Old Fred. Rd.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis of Cerebral Vessels</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis of Cerebral Vessels</u>					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY	
		331 Brena Ave				HOUR A.M. Month Day Year P.M. 19	
		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)	
						21f. LOCATION Street or R.F.D. No. City or Town County State	
		22a. I certify that (I) (this hospital) attended the deceased from 1/8/1860, 19, to 3/4/68, 19, that (I) (we) last saw the deceased alive on 3/5/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		Cliff Ratliff		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		3/5/68	
		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
		Cliff Ratliff, Jr., M.D.		4605 Edmondson Ave., Baltimore, Md. 21229			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3/7/68		Loudon Park Cemetery		Baltimore, Maryland	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Sterling Funeral Estate-736 Edmondson Ave.		MAR 8 1968		John J. Judge			



CERTIFICATE OF DEATH

J3832

1 DECEASED NAME (Type or print) MILTON R. STUART			2a. DATE OF DEATH Month MAR Day 28 Year 1968		2b. HOUR 11⁰⁰ A.M.
3. SEX M	4 RACE W	5. DATE OF BIRTH 2/12/11		6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTO		
10. CITY OR TOWN OF DEATH RURAL	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BOX 79 RTE 15	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY AIR CRAFT	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD	13b. COUNTY BALTO.	13c. CITY OR TOWN RURAL	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER BOX 79 RTE 15	
14. FATHER'S NAME First CHARLES Middle STUART Last	15. MOTHER'S MAIDEN NAME First ? Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) LINK (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 212-09-3622	17. INFORMANT MICHAEL STUART		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) metastatic carcinoma 1950 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) abdominal carcinoma site DUE TO, OR AS A CONSEQUENCE OF (c) undetermined					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 mos.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from November, 1967 , to March 28, 1968 , that (I) (we) lost saw the deceased alive on March 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.B. Littleton M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-29-68	
22d. PHYSICIAN'S NAME (Type) J. B. LITTLETON M.D.		22e. ADDRESS 1012 OLD N. PT. RD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3/30/68	23c. NAME OF CEMETERY OR CREMATORY EBENEZER	23d. LOCATION (City or Town) (County) (State) BALTO MD.		
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	25a. REC'D BY REGISTRAR APR 2 - 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

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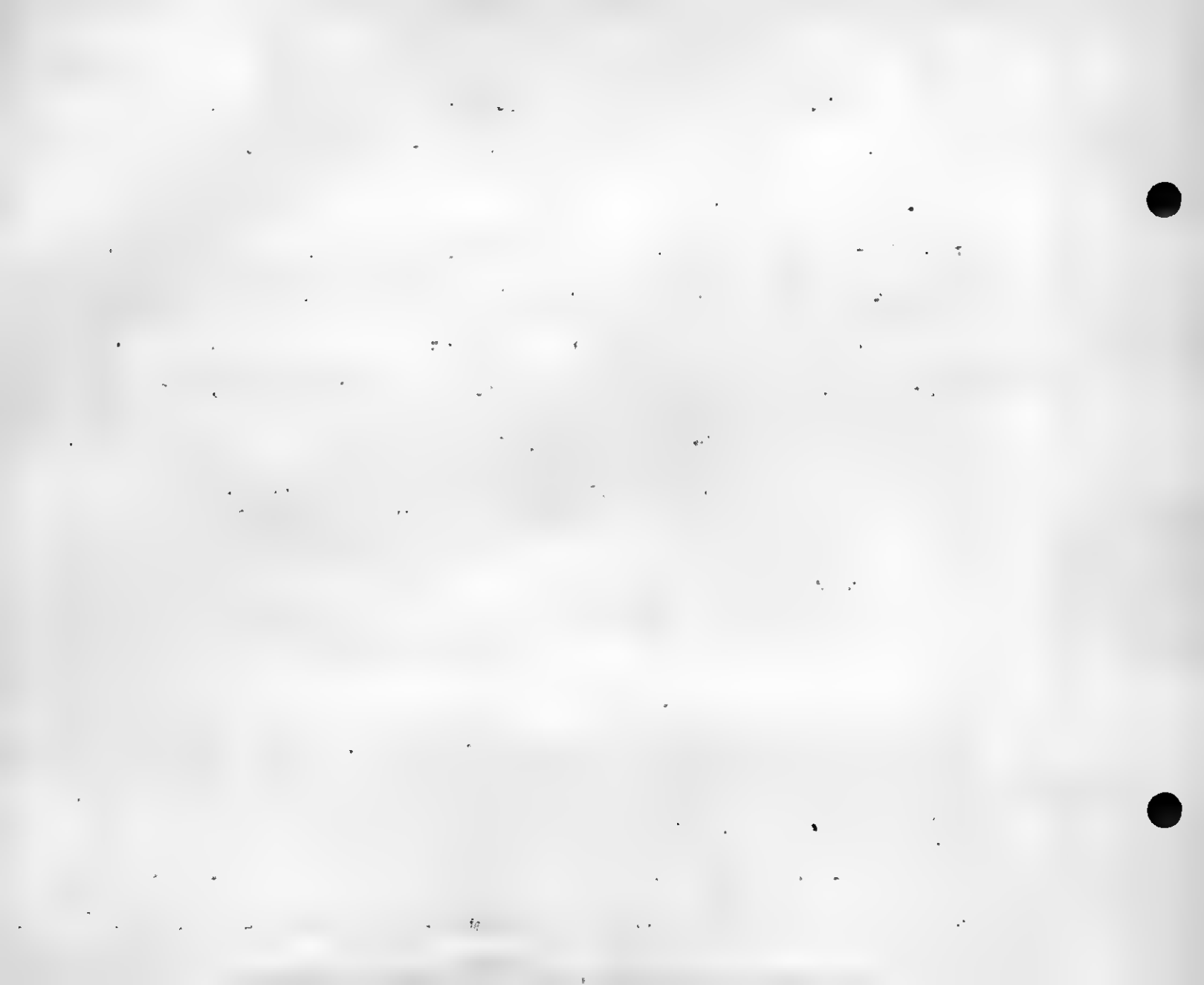
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VR A15 M
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) LEROY ANTHONY SULLIVAN			2a. DATE OF DEATH Month March Day 15 Year 1968		2b. HOUR 4 A.M.
3. SEX Male	4 RACE White	5 DATE OF BIRTH March 17, 1929		6. AGE (In years last birthday) 38 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.
7a BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Fort Howard	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Policeman		12b. KIND OF BUSINESS OR INDUSTRY County
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8051 Gray Haven Road-21222	
14. FATHER'S NAME First Middle Last Anthony H. Sullivan		15. MOTHER'S MAIDEN NAME First Middle Last Sarah V. Meade			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war, dates of service) Yes PL-28		16b. SOCIAL SECURITY NO. 218 22 44 06		17. INFORMANT Address Clinical Rcds, VA Hospital, Fort Howard, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA 153.5 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF COLON WITH METASTASIS TO DUE TO, OR AS A CONSEQUENCE OF LYMPH NODES, HEART, PERICARDIUM (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ADENOMA THYROID					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from March 10, 1968 , to March 15, 1968 , that (I) (we) last saw the deceased alive on March 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. D. TALBERT, M.D.				22c. DATE SIGNED 3/15/68	
22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.		22e. ADDRESS VA Hospital, Fort Howard, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/18/68	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR JOHN J. DUDA FUNERAL HOME		ADDRESS 1922 Wise Ave. Balto 22, Md.		25a. REC'D BY REGISTRAR MAR 18 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

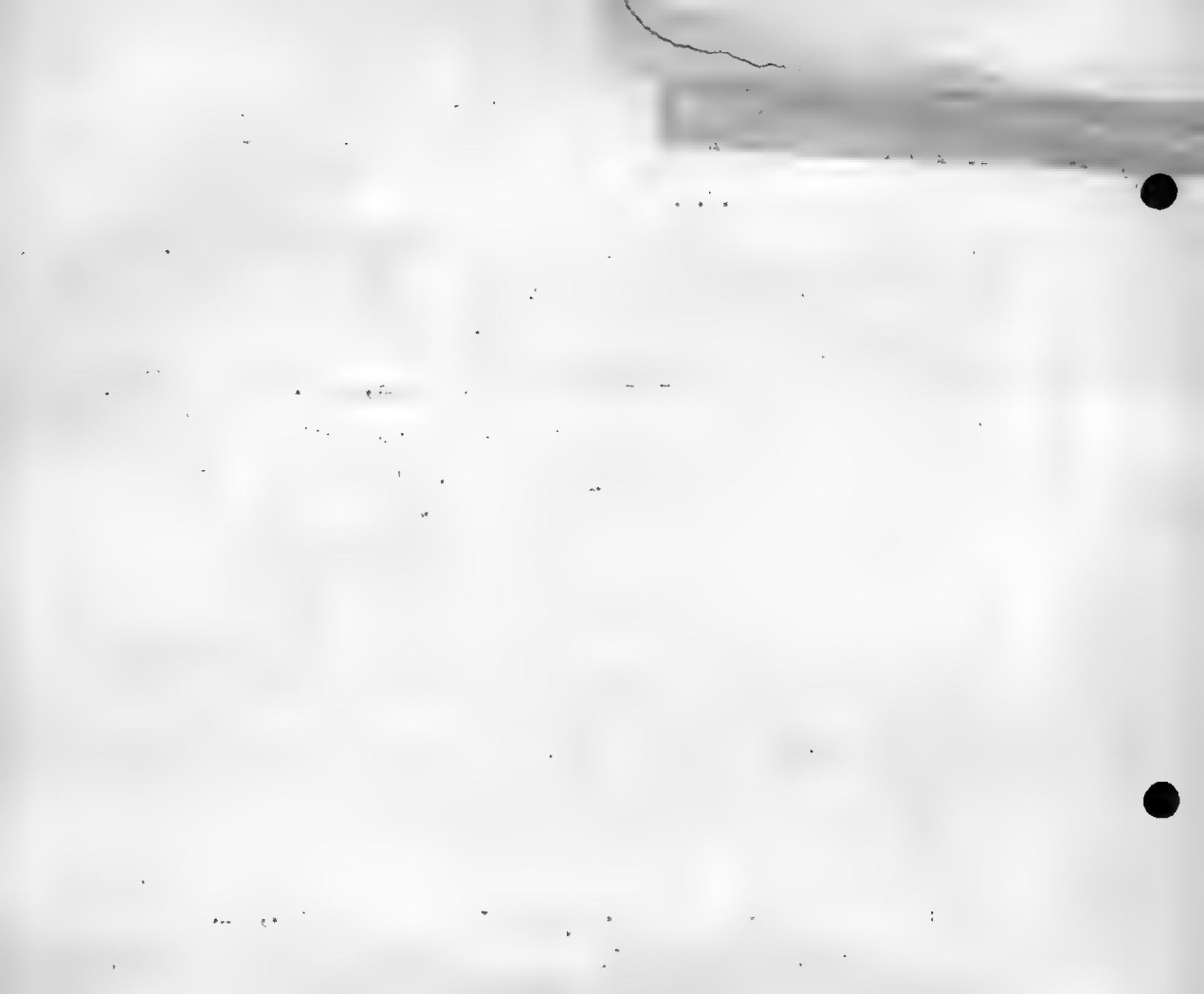
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03851

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Frank</i>			2a. DATE OF DEATH Month <i>3</i> - Day <i>1</i> - Year <i>68</i>			2b. HOUR M <i>1</i>								
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>12-22-81</i>		6. AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS <i>8</i> DAYS <i>15</i>		IF UNDER 24 HRS HOURS <i>15</i> MIN <i>00</i>				
7a. BIRTHPLACE (State or foreign country) <i>ITALY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Grand Bowling</i>					
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Balto. Co. Gen. Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Proprietor Bowling Al.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Grand Bowling</i>			12c. KIND OF BUSINESS OR INDUSTRY <i>Grand Bowling</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1811 Greencastle Dr.</i>		13f. ALLEY <i>Alley</i>				
14. FATHER'S NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>			15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO. <i>218-22-7416</i>			17. INFORMANT Address <i>21237 Virginia Palm, Dght. 1811 Greencastle Drive</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>Sen. ASCVD, Hemipia, 2°</i> DUE TO, OR AS A CONSEQUENCE OF, (c) <i>Chronic Renal Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <i>2-1</i> , 19 <i>68</i> , to <i>3-1</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3-1</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Madama Simon</i>		22c. DATE SIGNED <i>3-1-68</i>		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/4/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Balto., Md.</i>		24. FUNERAL DIRECTOR <i>Schimunek Funeral Home</i> <i>3331 Brehms Lane #13</i>						
25a. REC'D BY REGISTRAR <i>MAR 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-68
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03835

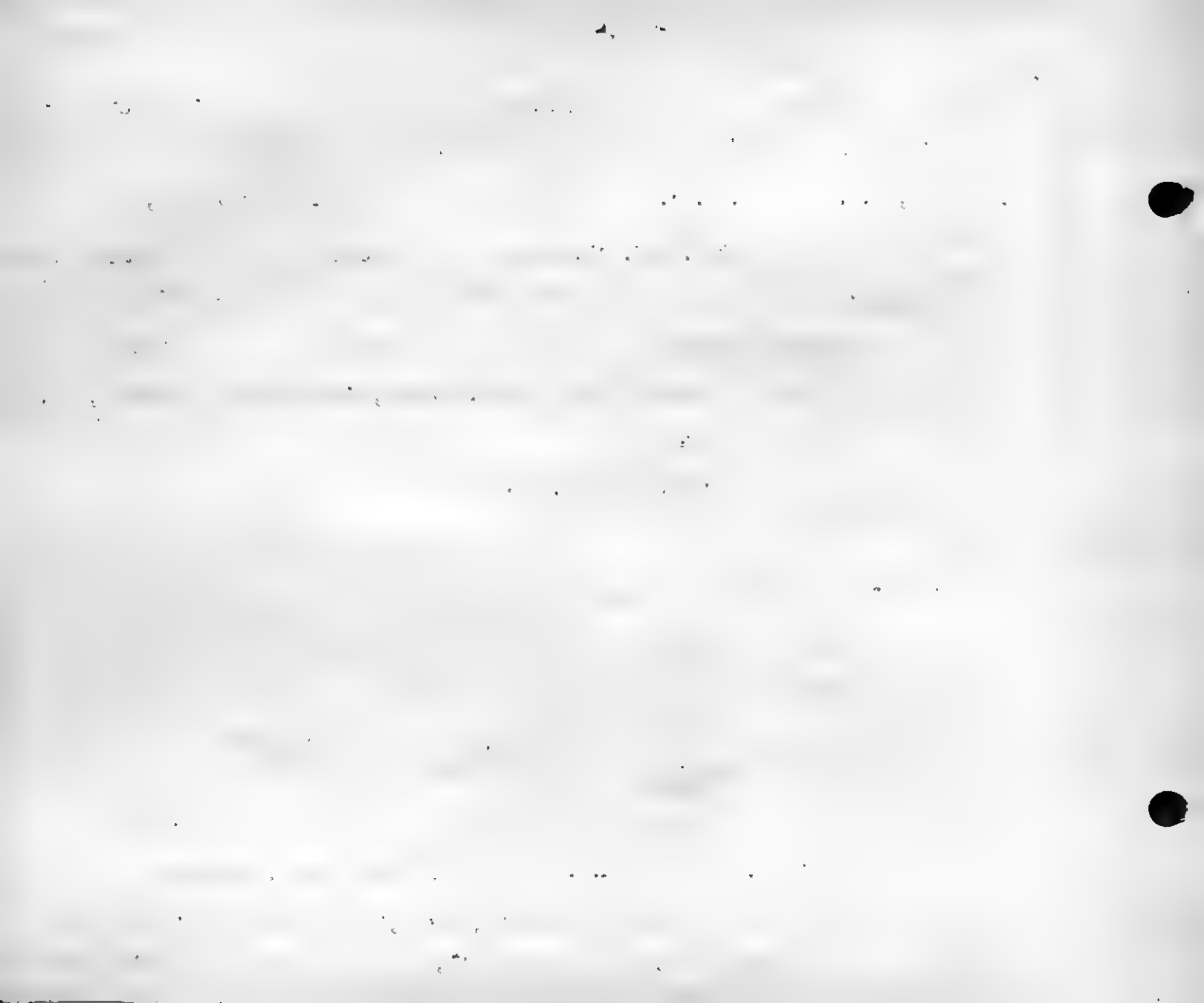
1. DECEASED NAME (Type or print) Thomas			First O			Middle Swann			Last			2a. DATE OF DEATH Month 3 Day 28 Year 68			2b. HOUR 2:00 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH June 1, 1899			6. AGE (In years last birthday) 68 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.								
10. CITY OR TOWN OF DEATH Parkville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8226 Old Harford Rd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Silver Finisher			12b. KIND OF BUSINESS OR INDUSTRY Kirk Co								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Parkville			13c. CITY OR TOWN Parkville			3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 8226 Old Harford Rd					
14. FATHER'S NAME Joseph			First Swann			Middle Mary			Last Hutchins			15. MOTHER'S MAIDEN NAME Mary W Hutchins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-10-8089A			17. INFORMANT Address Same Mrs Ada M Swann								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart - sudden</u> DUE TO, OR AS A CONSEQUENCE OF <u>2 generalized myocardial infarctions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>6 mo.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>March</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>March 28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>S.E. Harris</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 3/28/68								
22d. PHYSICIAN'S NAME (Type) S.E. Harris M.D.			22e. ADDRESS 8100 Harford Rd Baltimore, Maryland														
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE 4/1/68			23c. NAME OF CEMETERY OR CREMATORY Parkwood			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland								
24. FUNERAL DIRECTOR Leonard J Ruck			ADDRESS Baltimore, Maryland			25a. REC'D BY REGISTRAR MAR 29 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

2007 22.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

Item 23b Film G388 4/9/68 kk 853										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
EMIL					- SWISTAK					Month 3 Day 27 Year 68					1:30P M									
3 SEX					4 RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)									
MALE					WHITE					12/9/21					48 YRS									
7a. BIRTHPLACE (State or foreign)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
NEW YORK, N.Y.					U. S. A.										BALTIMORE COUNTY, Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
FORT HOWARD					VET. ADM. HOSPITAL					MOTORMAN					COPPER & BRASS									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?									
STATE MARYLAND										BALTIMORE					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET AND NUMBER					14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
2621 Fait Avenue					First Middle Last					First Middle Last														
STEPHEN SWISTAK					MARY					BERG IK														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
YES					WW 11					058 14 97 93					CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) UREMIA																								
DUE TO, OR AS A CONSEQUENCE OF																								
DIABETES MELLITUS																								
DUE TO, OR AS A CONSEQUENCE OF																								
lost. 261X																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																								
CARCINOMA OF PHARYNX																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION					City or Town County State									
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from 12/11/67, 19__, to 3/27/68, 19__, that (X) (we) last saw the deceased alive on 3/27/68, 19__, and that in our opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
Gracito V. Patricio															3/27/68									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
GRACITO V. PATRICIO, M.D.															VAH FORT HOWARD, MARYLAND									
23a. BURIAL, CREMAT. ON, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
REMOVAL (Specify)					3/30/68					CALVERY CEMETERY, QUEENS, NY					LONG ISLAND NEW YORK									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
SOBRIESKI FUNERAL HOME, 161 DRIGGS AVE, BROOKLYN NY															APR 1 1968					Charles Judge				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 3, 4, 5 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Film G398 3/13/68 kk MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First Middle Last Raymond E. Talley, Sr.		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year Mar. 4, 1968		2b. HOUR 2:00 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 17, 1904	6. AGE (In years last birthday) 63 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 38 Portship Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Paper hanger
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Wilford Talley		15. MOTHER'S MAIDEN NAME First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Raymond E. Talley, Jr. 204 E. Joppa Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17-S-C-V-DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE M.B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/4/68
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ADDRESS 6800 MCKINLEY AVE. Dundalk, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 7, 1968	23c. NAME OF CEMETERY OR CREMATORY Parkwood, Cemetery	23d. LOCATION (City or Town) (County) (State) Parkville, Md.	
24. FUNERAL DIRECTOR Ulrich Funeral Home, Dundalk, Md.		25a. REC'D BY REGISTRAR DATE MAR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Young

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-103-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

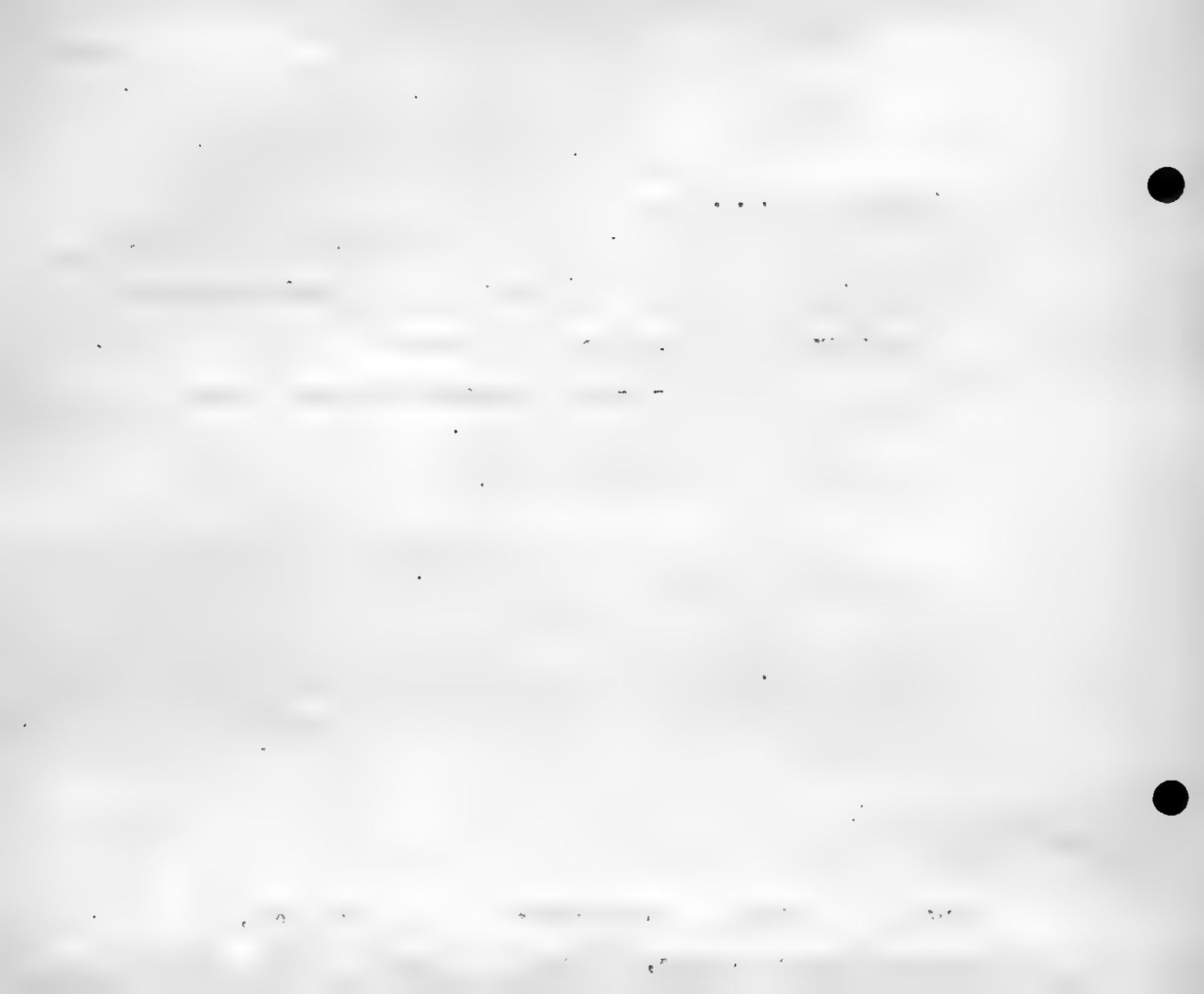
1. DECEASED NAME (Type or Print) Ethel Mae Taylor			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 18 Year 68			2b. HOUR 12:30 M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 1, 1906	6. AGE (In years last birthday) 61 YRS	F UNDER 1 YEAR MONTHS 0 DAYS 0		F UNDER 24 HRS HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD Month 3 Day 18 Year 68	2d. HOUR 4:45 M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Mandallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not a home, give street address) Baltimore County General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		2b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD.			13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. 1 Park Heights Ave.		
14. FATHER'S NAME First Luther Middle Elmer Last Wagoner			15. MOTHER'S MAIDEN NAME First Lula Middle Mae Last Dwyer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 213-25-3430		17. INFORMANT Mrs. Frank Klein			ADDRESS Maryland 21118 Pikesville	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James N. Frederick M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/18/68			
EXAMINER'S NAME (Type) James N. Frederick			ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>			1311 Francisco			
			DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			Baltimore			
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 21, 1968		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) Pikesville		(County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wells Funeral Home, Pikesville - 8-1164				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit 1. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MIDDLE											
<div>Item 21c File # 688</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>3/27/68 kk 855</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
CHARLES F			TESTUDINE			<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year MAR 17 1968			420 M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d HOUR
M	W	11-18-45	22 YRS	MONTHS	DAYS	HOURS	MIN	MAR 17			420 M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.		BALTIMORE							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH HOSPITAL				Lineman		Telephone Co			
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
MD						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5511 Greenleaf Rd	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			First Middle Last			First Middle Last		
Salvatore C			Testudine			Margaret H			Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
Yes			215-44-0624			Salvatore Testudine			Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INHALATION PNEUMONIA											1 DAY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) SMOKE AND FLAME											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)											
40% 2nd Burns of Face Arms, Chest											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				4 AM 3/16 1968		CRASHED / RAN INTO / TRIP / 1000 / SUPER					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
		HOME		5511 GREENLEAF RD		BALTIMORE		MD		MD	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED			
WILLIAM A. PINEBURY				M.D.				3-17-68			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, City or Town, or County)			
WILLIAM A. PINEBURY											
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		3/21/68		Holy Redeemer		Baltimore, Md					
24. FUNERAL DIRECTOR						25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc Baltimore, Maryland						DATE MAR 18 1968		Charles Judge			



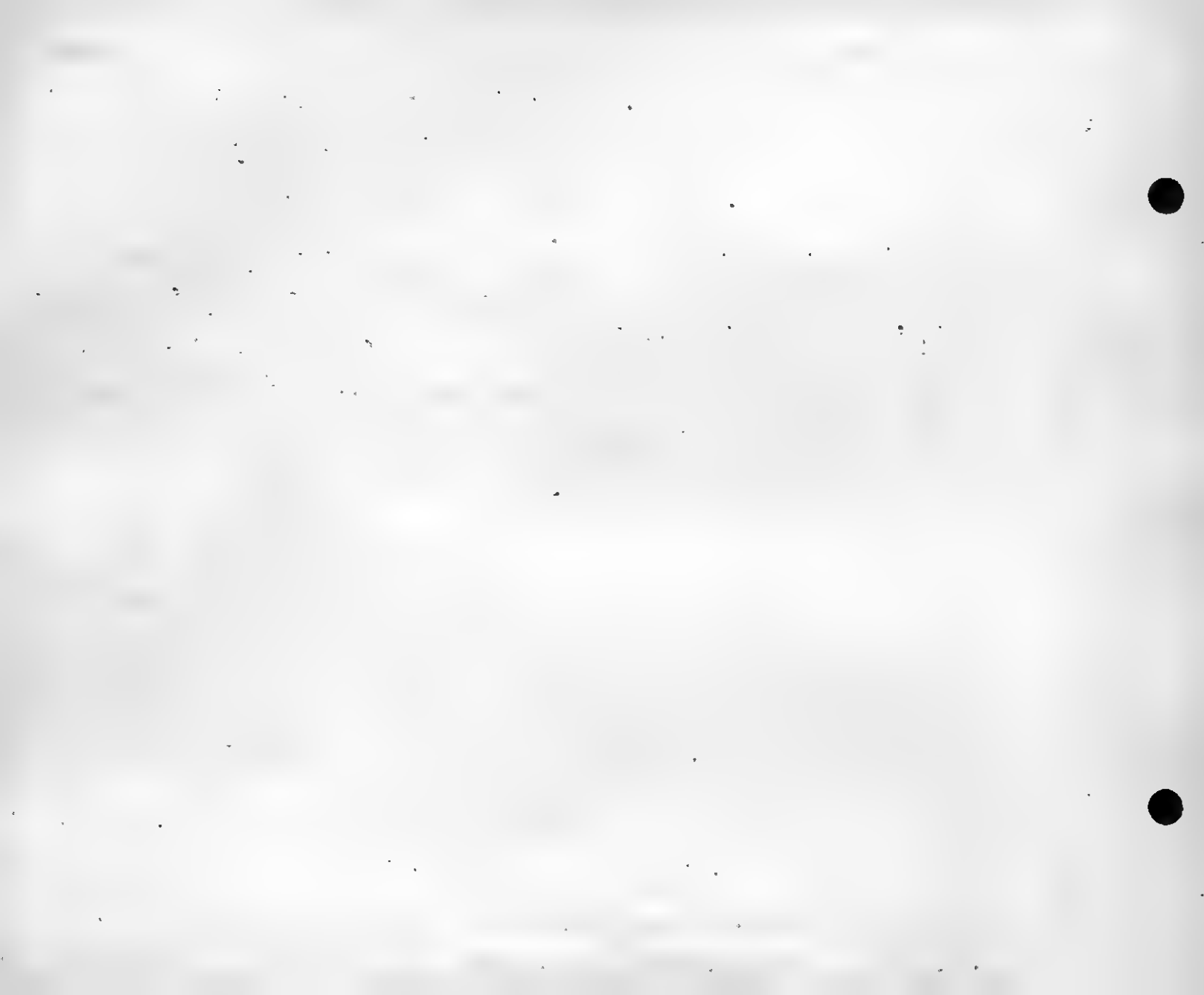
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Doroathy Love Thomas</i>			2a. DATE OF DEATH <i>3</i> Month <i>22</i> Day <i>68</i> Year			2b. HOUR <i>6:47</i> M				
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>8-5-1890</i>		6. AGE (In years last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.				
10. CITY OR TOWN OF DEATH <i>Towson md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Baltimore Hospital Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Towson</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>200 Rodgers Forge Rd.</i>		
14. FATHER'S NAME First Middle Last <i>Albert A. Love</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Eleanor Jackson Love</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO. <i>4409</i>		17. INFORMANT <i>Mr. Albert Thomas, Jr., 102 Greenidge Court</i>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia Broncho-</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1001</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>46</i> , to <i>22 Mch</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>22 Mch</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Charles H. Reier M.D.</i>				DEGREE <i>DEGREE</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE, SIGNED <i>22 Mch 68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Charles H. Reier</i>				22e. ADDRESS <i>6701 York Road</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/23/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sherwood Episcopal Church</i>		23d. LOCATION (City or Town) (County) (State) <i>Cockeysville Md/</i>				
24. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co. 4905 York Rd. 21212</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>MAR 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		

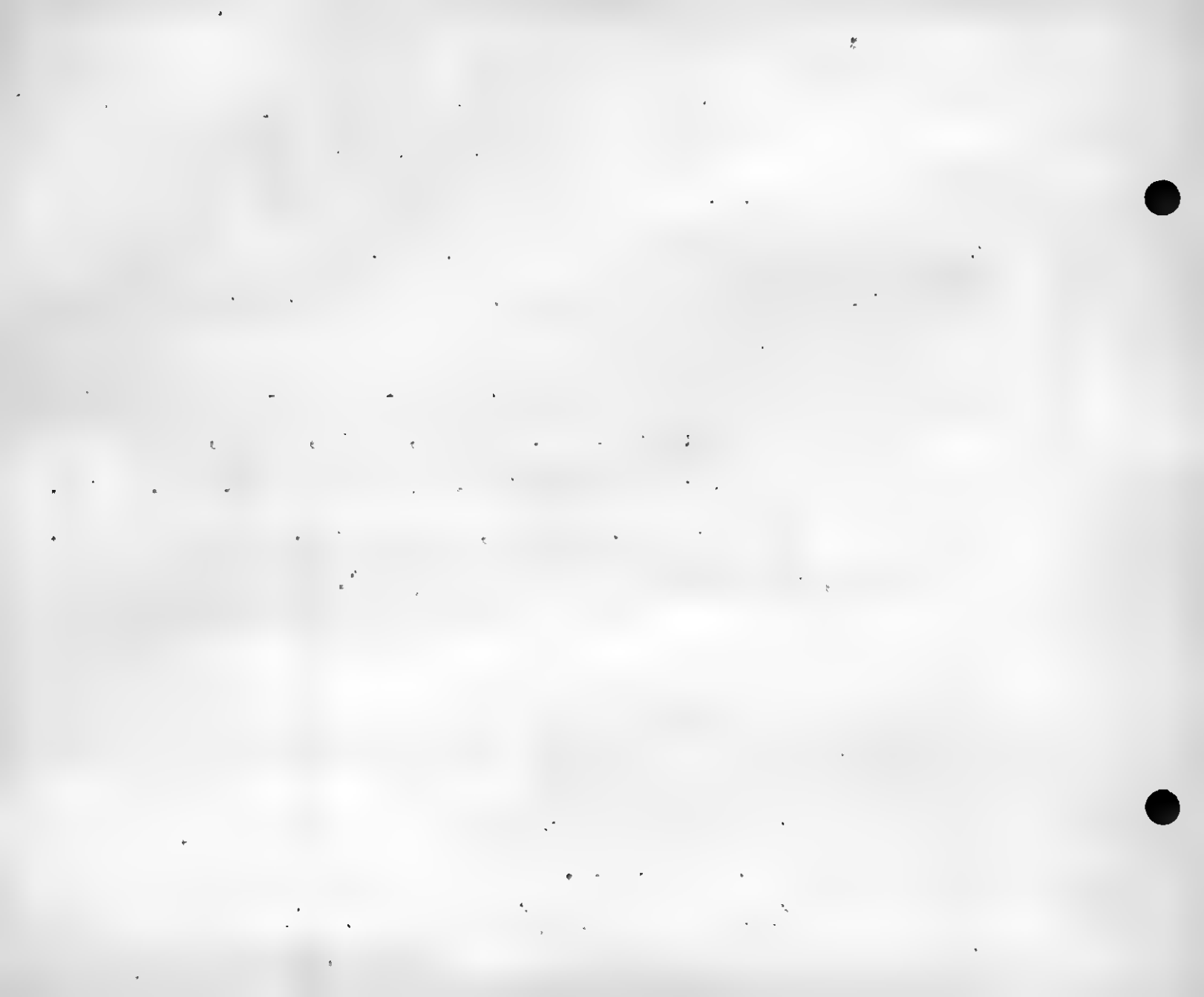


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Harry Milton Thompson			2a. DATE OF DEATH Month Day Year March 22, 1968			2b. HOUR 11:15 a. m.	
3 SEX male		4. RACE white		5. DATE OF BIRTH April 29, 1916		6. AGE (In years last birthday) 51 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1824 McHenry Street		14 FATHER'S NAME First Middle Last Morgan Thompson		15. MOTHER'S MAIDEN NAME First Middle Last Jessie Linden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death, 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular Ht. Dis. 5 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized. 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia, bronchial, organism undetermined.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 18, 1940 , to March 22, 1968 , that (I) (we) lost saw the deceased alive on March 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Anthony J. Young</i>				22c. DATE SIGNED 3-25-68		22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/25/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Park		23d. LOCATION (City or Town) (County) (State) BALTO	
24 FUNERAL DIRECTOR ADDRESS 4401 E. Carroll Ave				25a. REC'D BY REGISTRAR MAK 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	

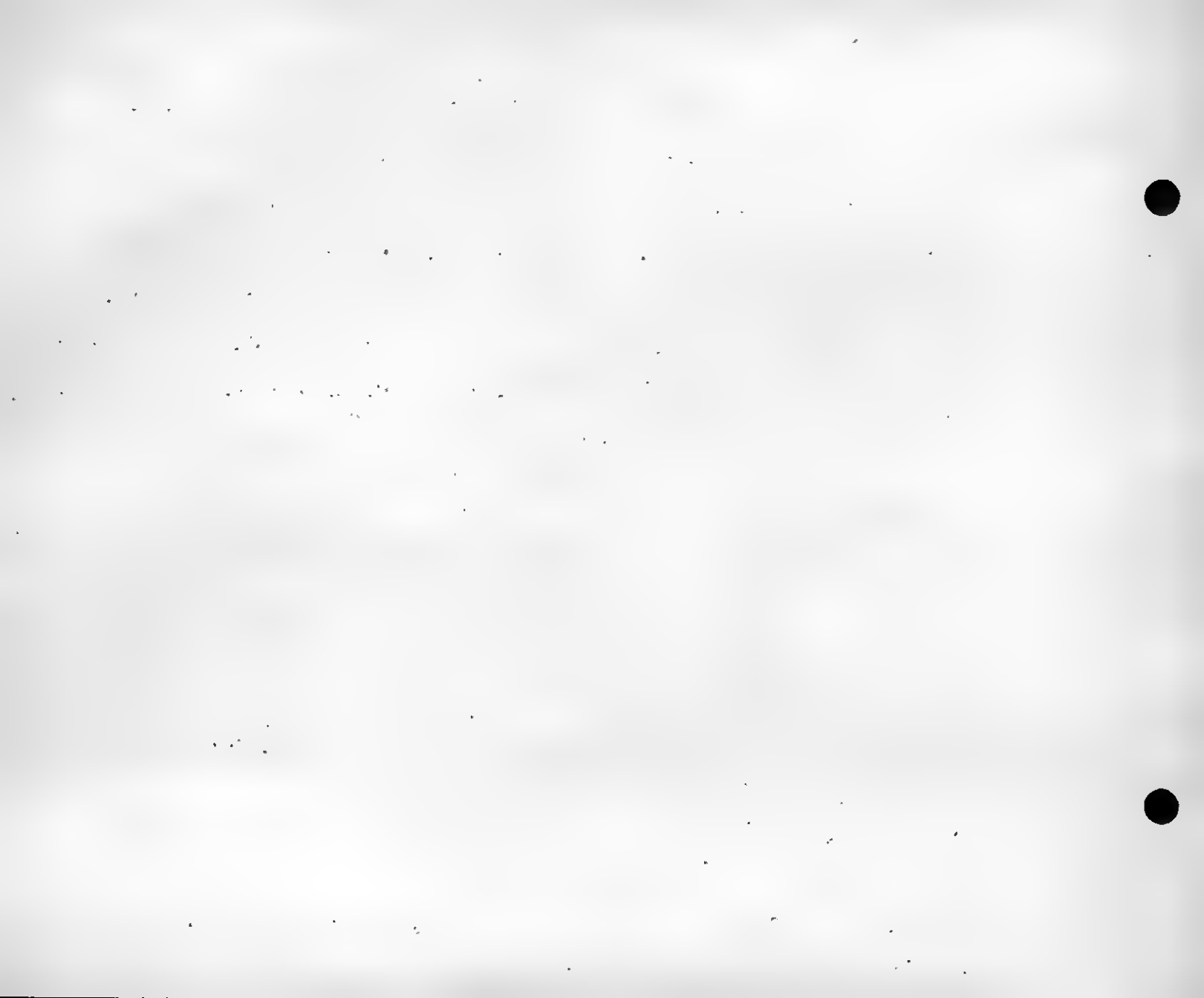


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Grace			Gibson	Tilyard	March 10, 1968			M			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Female		White		November 11 1877			90 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Maryland		U.S.A.				Baltimore					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson		Chesapeake Manor Nursing H.				Housewife					
13a USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13a INS DE CTY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland				Baltimore				224 Homewood Terr.			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Henry			Gibson			Caroline			Ann	Hayes	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT			Address		
no						Mrs. Dorothy G. Hoshall			Rt. 1 Box 213 Mt. Rd. Carmel		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Colon</u> 155.8 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
				1957		March 19		68			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 68</u> , that (I) (we) last saw the deceased alive on <u>March 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b SIGNATURE <u>W. G. Helfrich</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-11-68			
22d. PHYSICIAN'S NAME (Type) W. G. Helfrich						22e ADDRESS 506 Roland Ave. Baltimore, Md					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)
Burial		3/12/68		Loudon Park Cemetery			Baltimore, Maryland				
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a. REC'D BY REGISTRAR DATE MAR 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) John (None) Torma				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 3 21 1968		2b. HOUR 10:45 A.M.	
3 SEX Male	4 RACE Cau	5 DATE OF BIRTH 7-8-17	6 AGE (in years last birthday) 50 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD 3-21-68 Day Year 19 11 A.M.	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Maryland	
10. CITY OR TOWN OF DEATH Sparrows Point, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give place of death) Plant Dispensary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shipfitter		12b. KIND OF BUSINESS OR INDUSTRY Ship Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2924 Cornwall Road.							
14. FATHER'S NAME First Middle Last JOSEPH TORMA				15. MOTHER'S MAIDEN NAME First Middle Last ANNA HORVATH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 233-14-8920		17. INFORMANT ERNEST YAMBOR ADDRESS 5710 Ruatan St Berwyn Heights Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion							
DUE TO, OR AS A CONSEQUENCE OF 4100							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) Hypertensive Cardiovascular Disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
4100							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Melvin B. Davis		EXAMINER'S NAME (Type) Melvin B. Davis M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3/21/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 26 MAR 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD		ADDRESS		25a. REC'D BY REGISTRAR MAK 26 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

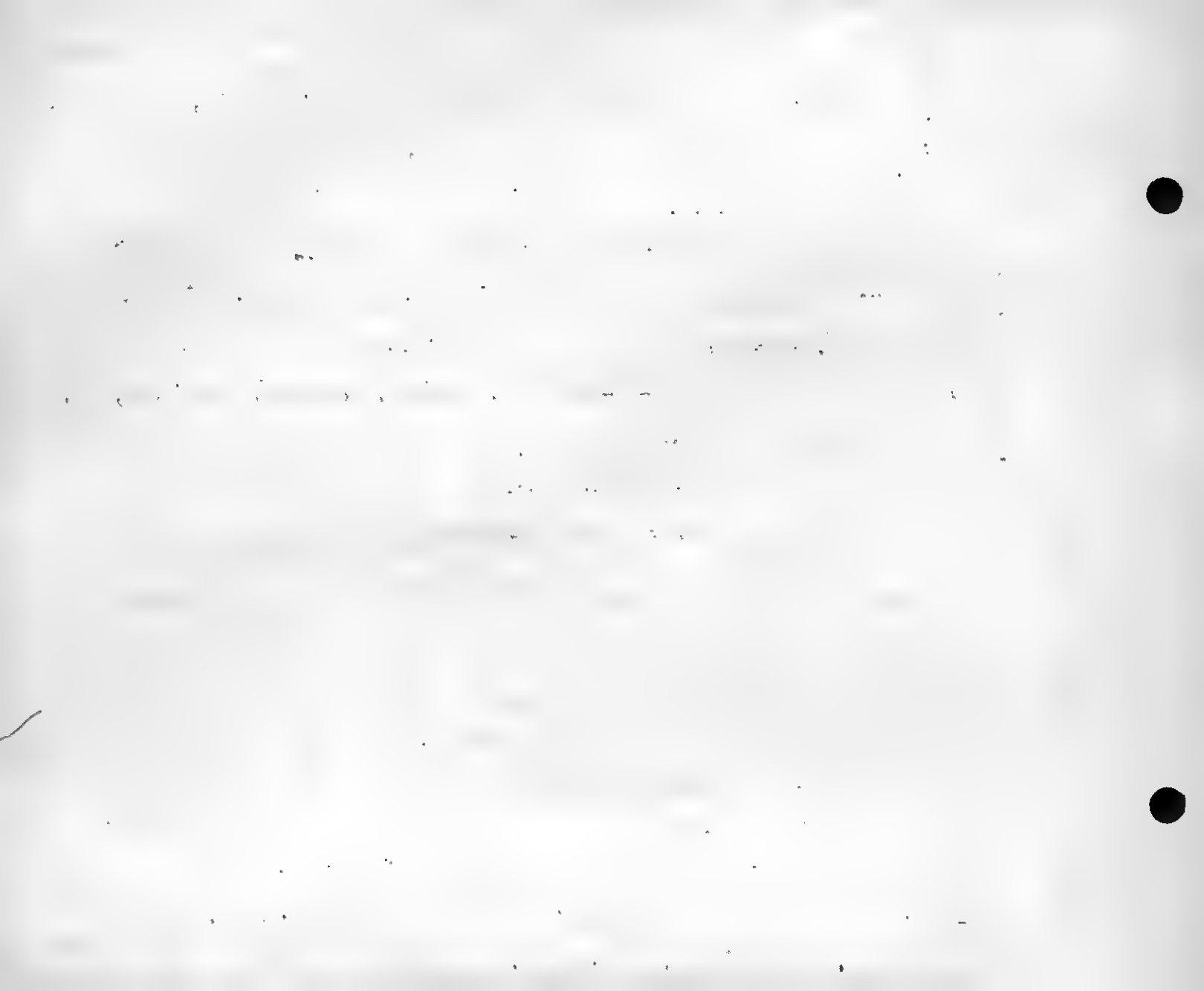


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) EARLE MORRIS TOWNSEND			2a. DATE OF DEATH Month MARCH Day 17 , Year 1968			2b. HOUR 3:00 AM			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH APRIL 8, 1905		6. AGE (In years lost birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		Md.	
10. CITY OR TOWN OF DEATH TOWSON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5623 PLYMOUTH RD. #21214			
14. FATHER'S NAME First Middle Last Willard T. Townsend			15. MOTHER'S MAIDEN NAME First Middle Last Ida Starkey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 213-01-8227		17 INFORMANT Address Mrs. Earle M. Townsend, Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Uremia 600 X DUE TO, OR AS A CONSEQUENCE OF (b) obstructive uropathy DUE TO, OR AS A CONSEQUENCE OF (c) hyperplasia of prostate Condit ions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from FEBRUARY 19, 1968 , to MARCH 17, 1968 , that he (we) last saw the deceased alive on MARCH 17, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence Misanik, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/17/68			
22d. PHYSICIAN'S NAME (Type) Lawrence Misanik, M.D.				22e. ADDRESS 7620 York Rd. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/1968		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or Town) (County) (State) Easton, Md.			
24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md.				ADDRESS		25a. REC'D BY REGISTRAR MAK 19 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

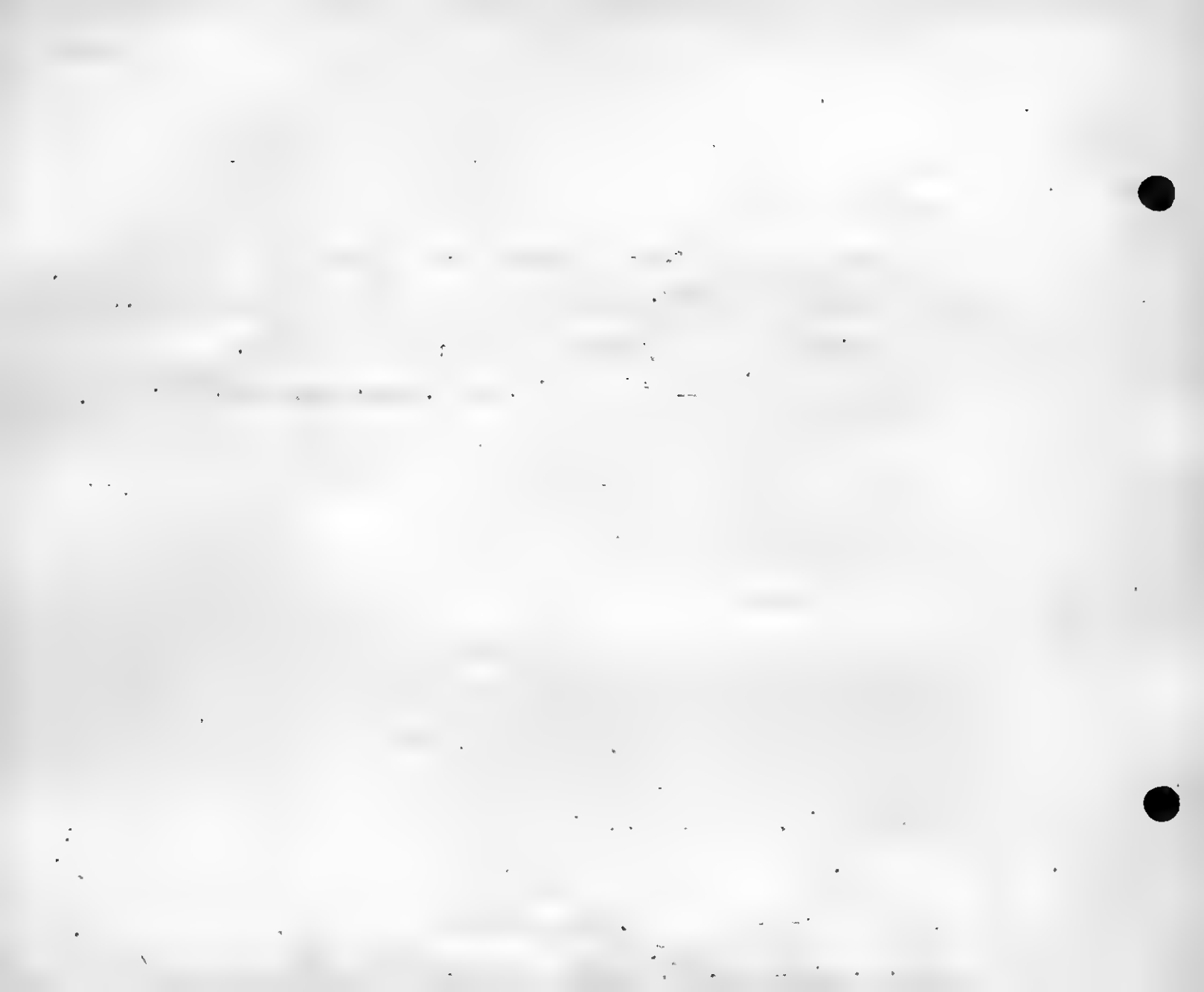


CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Cima E. Tracey</u>			2a. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>68</u>		2b. HOUR <u>11:0 P.M.</u>
3. SEX <u>Female</u>	4. RACE <u>CAUCASIAN</u>	5. DATE OF BIRTH <u>1-20-86</u>		6. AGE (In years last birthday) <u>82</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Balto Co</u> Md.		
10. CITY OR TOWN OF DEATH <u>Catonsville</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Shangri-La Nursing Home</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RES-DECEASED (Where deceased lived, if institution residence before admission) STATE <u>Maryland</u>	13b. COUNTY <u>BALTO.</u>	13c. CITY OR TOWN <u>Ellicott City</u>	13d. INSIDE CITY (L.M. 157) YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>21043 49 Evergreen Ave., Ellicott City</u>	
14. FATHER'S NAME First <u>George</u> Middle <u>Geaslen</u> Last <u>Elizabeth(Thomas) Geaslen</u>	15. MOTHER'S MAIDEN NAME First <u>Elizabeth(Thomas) Geaslen</u> Middle <u>Geaslen</u> Last <u>Geaslen</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO <u>--</u>	17. INFORMANT <u>Mr. Guy E. Tracey, Sr., Ellicott City, Md. 21043</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Iron Deficiency Anemia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>years</u> <u>years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4121</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>18 JAN, 1968</u> to <u>24 MAR, 1968</u> , that (I) (we) last saw the deceased alive on <u>24 MAR, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Ralph E. Urdike M.D.</u>	DEGREE <u>M.D.</u>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>26 MAR 68</u>
22d. PHYSICIAN'S NAME (Type) <u>Ralph E. Urdike M.D.</u>	22e. ADDRESS <u>31 Dogwood Drive, 21043</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-27-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>		
24. FUNERAL DIRECTOR <u>Witzke F. D., Baltimore, Md. 21229</u>	25a. REC'D BY REGISTRAR <u>MAK 2.6 68</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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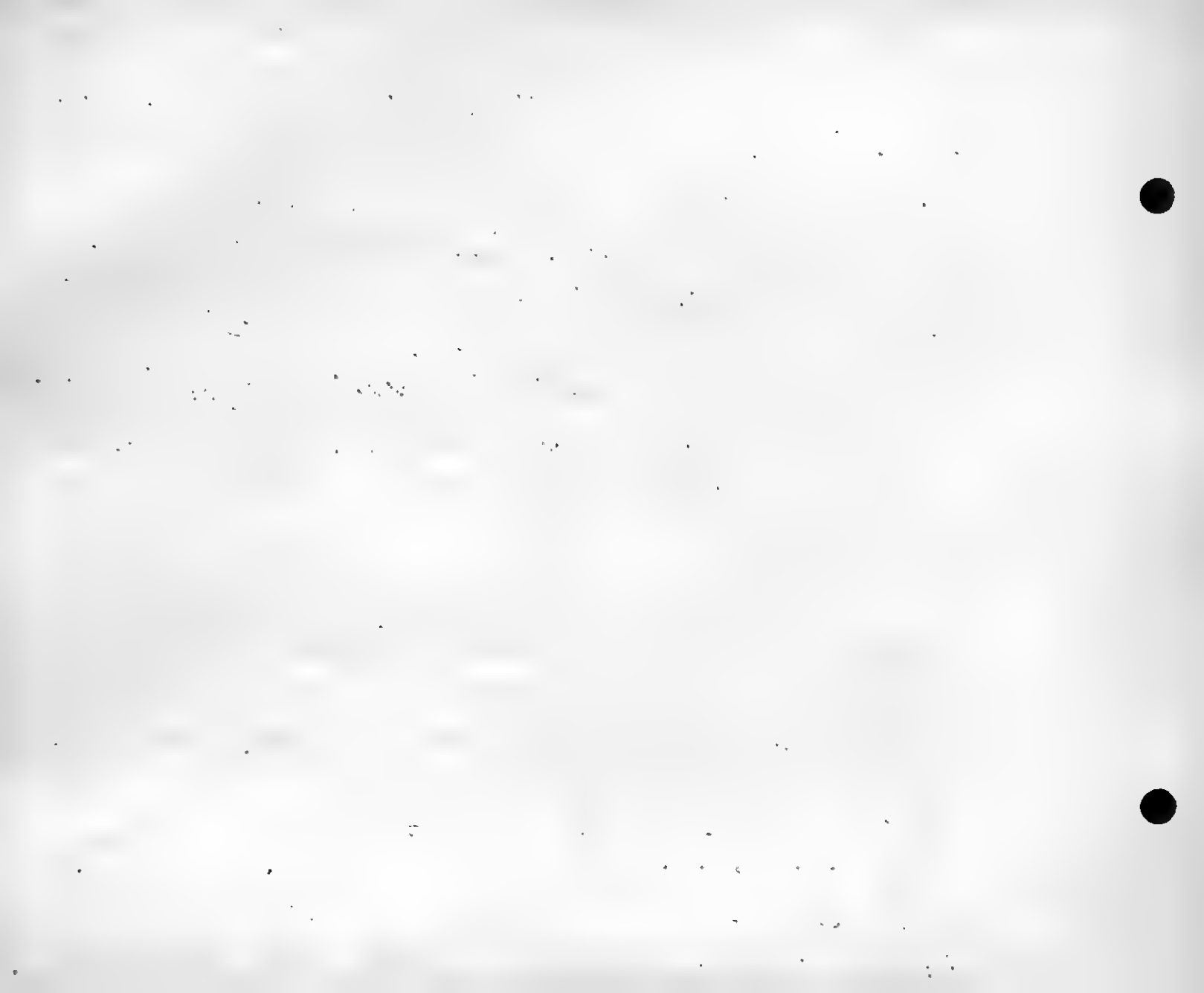


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <u>Eugene A. Trainor Jr</u>			2a. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1968</u>			2b. HOUR <u>2:55 AM</u>	
3 SEX <u>Male</u>		4. RACE <u>White</u>		5 DATE OF BIRTH <u>OCT 12, 1902</u>		6 AGE (in years last birthday) <u>65</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md	
10 CITY OR TOWN OF DEATH <u>Parkville</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>2913 Andover Court</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Civil-Eng</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Utilities</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>Edward</u> Middle <u>Trainor</u> Last <u>Trainor</u>		15. MOTHER'S MAIDEN NAME First <u>Mary E.</u> Middle <u>Fahney</u> Last <u>Fahney</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>212-05512</u>		17 INFORMANT <u>Mr. Eugene A. Trainor Jr</u> Address <u>515 W. 11th St</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>41 x 1</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4221</u> (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u> <u>4 years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus and hypothyroidism</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natrlly medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan. 25, 1968</u> , to <u>Mar. 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Mar. 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>S. J. Liu M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/7/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>S. J. Liu, M. D.</u>		22e. ADDRESS <u>5301 Harford Rd. Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/7/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u> <u>Md</u>	
24 FUNERAL DIRECTOR <u>Wm. W. Wedgell</u>		ADDRESS <u>6500 York Rd</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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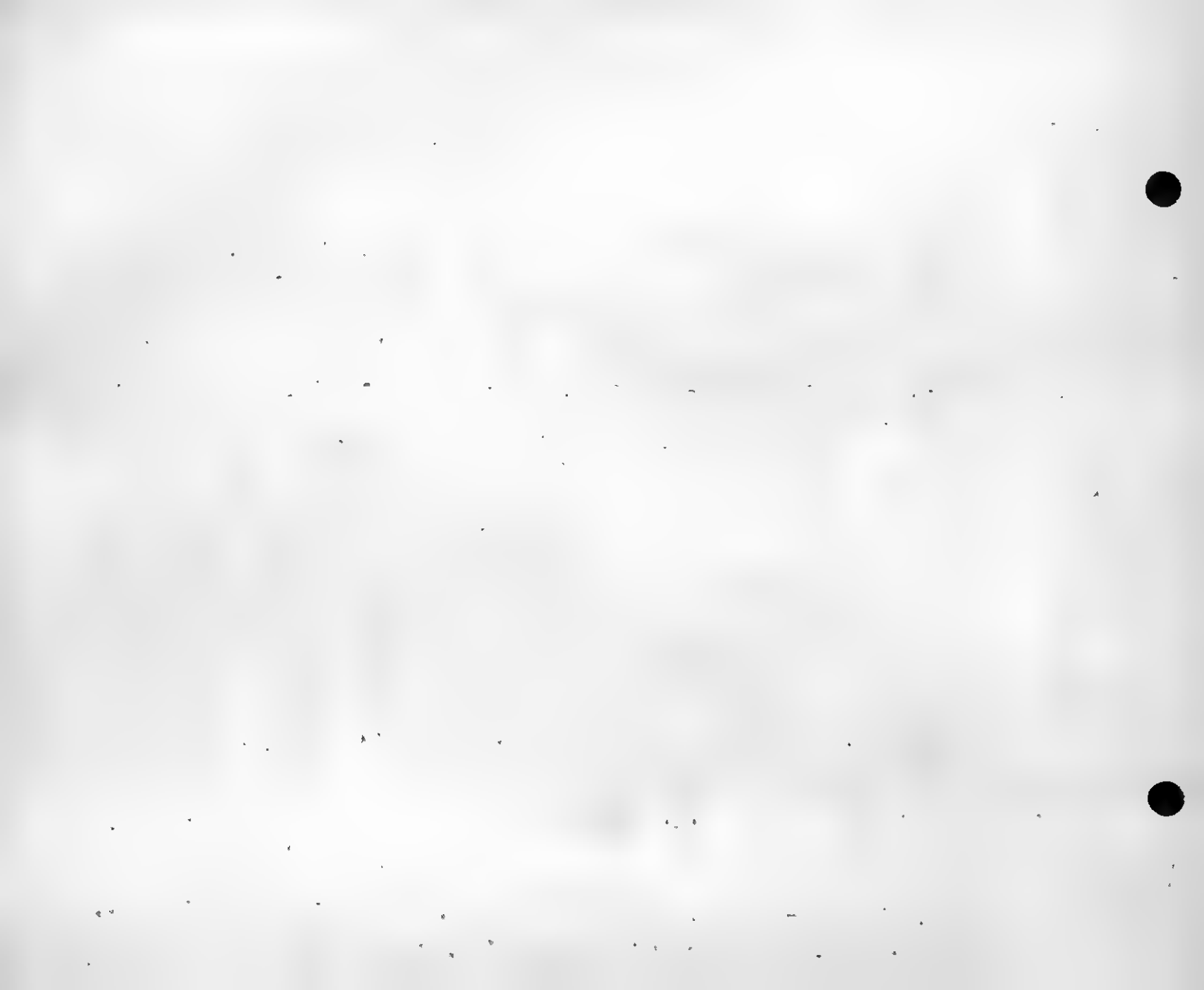
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Charles William Edward Treadwell			2a. DATE OF DEATH Month Day Year 3 - 18 - 68			2b. HOUR 3:00 A.M.			
3. SEX M		4. RACE W		5. DATE OF BIRTH 11-18-1890		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore, County		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 402 W. Pennsylvania Ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Office Manager		12b. KIND OF BUSINESS OR INDUSTRY Banking			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE COUNTY 402 W. Penn. Ave. Baltimore		13b. CITY OR TOWN Towson		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Charles E. Treadwell			15. MOTHER'S MAIDEN NAME First Middle Last Lucy Parlett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16b. SOCIAL SECURITY NO. 218-01-0093		17. INFORMANT Address Mrs. Theresa R. Treadwell Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION IMMEDIATE 4104 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY HEART DISEASE 15 YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (1) this hospital attended the deceased from 8/19, 1952, to 3/18, 1968, that (1) we last saw the deceased alive on 1/19, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.									
22b. SIGNATURE Donald L. Somerville				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 3/19/68	
22d. PHYSICIAN'S NAME (Type) Dr. Donald L. Somerville				22e. ADDRESS 25 W. Pennsylvania Ave.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/19/68		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Foxboro, Mass.		25a. REC'D BY REGISTRAR DATE MAR 19 1968	
25b. REGISTRAR'S SIGNATURE Charles J. J...									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
VINCENT					TRUSCH	March 9, 1968		12:15A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		March 20, 1897		70		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
BALTIMORE		USA				BALTIMORE Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON 4			St. Joseph Hospital			Standard Oil Co.-Ret.			
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland						Baltimore		3927 Hudson St. #24	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Joseph					Trusch	Eva			Lansburger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			214-01-4194			Katherine Trusch: 3927 Hudson St. Balto., 24, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that he (this hospital) attended the deceased from February 27 1968 to March 9, 1968, that he (we) last saw the deceased alive on March 9, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) not view the body after death.									
22b. SIGNATURE <u>Camilo Tomboc</u>						DEGREE ATTENDING PHYS.		22c. DATE SIGNED March 9, 1968	
22d. PHYSICIAN'S NAME (Type) Camilo Tomboc, M.D.						22e. ADDRESS 7920 York Rd. Towson 4, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		3-13-68.		Sacred Heart Cen.		7401 German Hill Rd., Md.			
24. FUNERAL DIRECTOR <u>Charles S. Ziller</u>		ADDRESS 901 S. Conkling St. Balto., 21224, Md.		25a. REC'D BY REGISTRAR DATE MAR 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Ziller</u>			

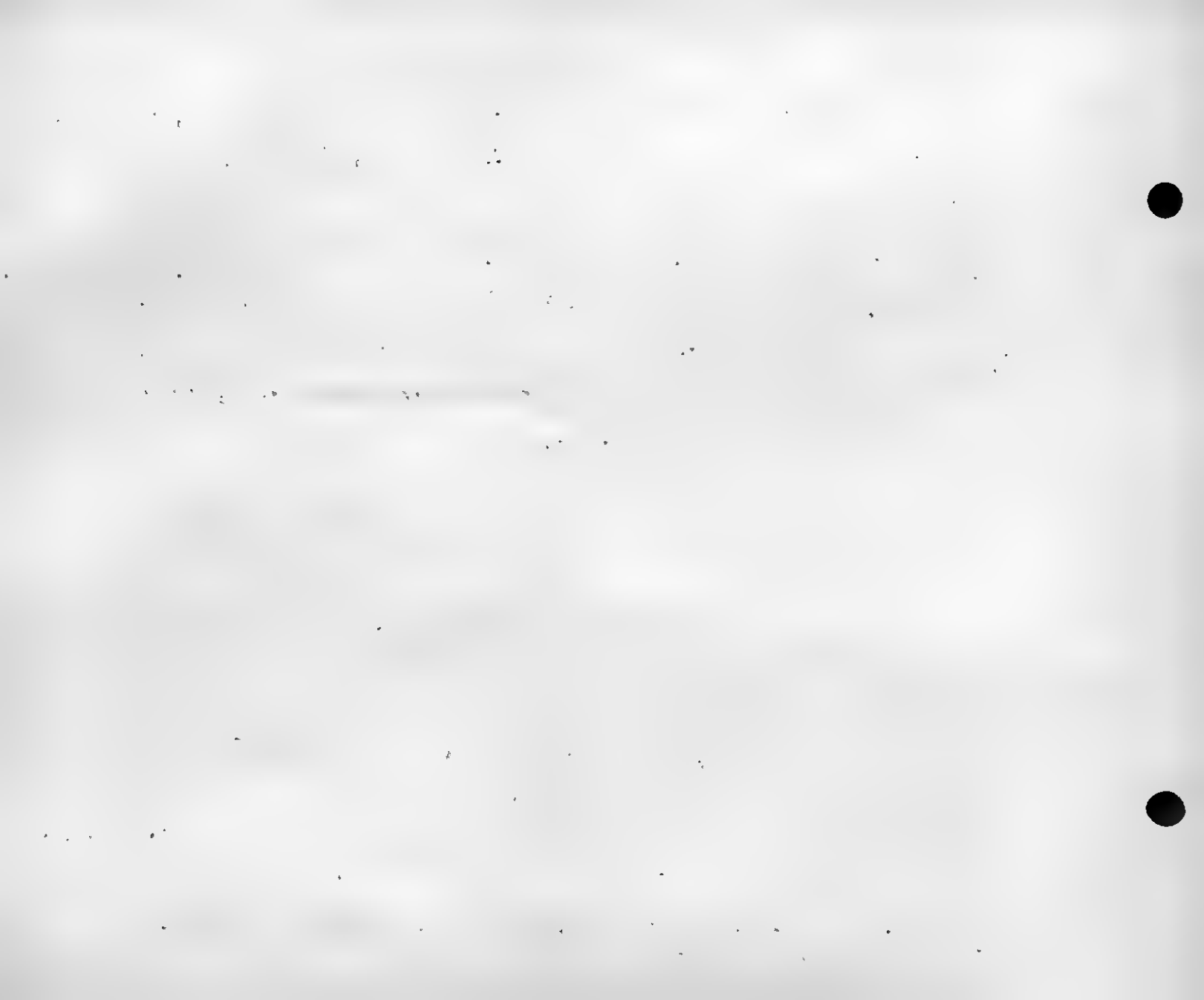


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M			
MICHAEL			FRANK	TUREK	March 22, 1968			3:30	M			
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS				
Male		White		September 10, 1886		81 YRS.		IF UNDER 24 HRS HOURS MIN.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		USA				Baltimore Md.						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson			St. Joseph Hospital			retired-Coffee Roaster		H.M. Wagner Co.				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland					Balto., 21213				3422 Belair Rd.			
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last	
Turek						Mary Hynek						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT Address						
no						Mary Ruby Turek, wife, above						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Liver</u> <u>197.8</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital), attended the deceased from <u>March 9, 1968</u> to <u>March 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <u>Anibal Escobar</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED March 22, 1968				
22d. PHYSICIAN'S NAME (Type) <u>Anibal Escobar, M.D.</u>						22e. ADDRESS <u>7620 York Rd., Towson, Maryland-21204</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)		
Burial			3/25/68		Holy Redeemer Cem.		Baltimore, Md.					
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>						25a. RECEIVED BY REGISTRAR DATE <u>MAR 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18-1
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
EMMA		P.		VAN		CURA		March		4		1968		7:00		A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Female	White	9-20-1909		58 YRS		MONTHS		DAYS		March		4		1968		6:00 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
Balto., Md.		U.S.A.				Baltimore											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Balto., Fort Howard		5 Chestnut Ave		Factory Worker		Candy											
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before)		13b. CITY OR TOWN		3a. INSIDE CITY LIM 157		13c. STREET AND NUMBER											
Maryland		Baltimore		Fort Howard		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5 Chestnut Avenue									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
James		?		Poledna		Emma		?		Pokorny							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		215-C1-9587		John W. Vancura		5 Chestnut Ave Fort Howard, Md.											
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>																	
157.7																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) _____																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
157.8																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
						19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE						Werner U. Spitz, M.D.						22b. DATE SIGNED					
EXAMINER'S NAME (Type)						Werner U. Spitz, M.D.						3/5/68					
						CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
						ASSISTANT MED. CAL. EXAMINER <input checked="" type="checkbox"/>											
						DEPUTY MED. CAL. EXAMINER <input type="checkbox"/>											
						ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
Burial						3-7-1968						Prospect Hill Cem.					
												23d. LOCATION (City or Town) (County) (State)					
												Towson Balto. Md.					
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REGISTRAR					
Wm. Cook-Brooks, Inc.						1217 St. Paul St. Balto. 21202						DATE MAR 8 1968					
												25b. REGISTRAR'S SIGNATURE					
												J. Charles Jones					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		2c. MIN	
First Middle Last Robert D. Van Devender					Month Day Year March 24, 68			2:00		PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.	
Male		White		7/6/19		48 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. Va.		U.S.A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				St. Joseph Hospital				Electrician		Steel Bethlehem	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland						Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4112 Century Road #21206	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
First Middle Last Sylvan Van Devender					First Middle Last Grace Holy Schumann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT					
Yes				WW 11		Mrs. Gertrude VanDevender Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary malignancy.											
16d1 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No City or Town County State						
22a. I certify that (this hospital) attended the deceased from March 23, 1968, to March 24, 1968, that (I) (we) lost the deceased alive on March 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
Ismael Jamora, M.D.								March 24, 1968			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS			
								7620 York Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3/27/68		Gardens Of Faith		Baltimore		Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck, Inc. Baltimore, Md						MAR 26 1968		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113 (4)
30M REV 11/58

03864

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03852

1 DECEASED-NAME (Type or print) First Middle Lost Frank Joseph Voit		2a DATE OF DEATH Month Day Year March 26 1968		2b HOUR 8:30 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH January 16, 1907	6 AGE (In years last birthday) 61 YRS.	
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman -	12b. KIND OF BUSINESS OR INDUSTRY Pollack-Blum	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 3333 Lyndale Avenue
14. FATHER'S NAME First Middle Lost Frank J. Voit		15 MOTHER'S MAIDEN NAME First Middle Lost Lottie Lasinski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes	16b. SOCIAL SECURITY NO WW 2 216-10-7004	17. INFORMANT Address Miss Margaret A. Voit, sister, above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated diverticulitis with peritonitis DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute renal failure				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (this hospital) attended the deceased from March 23, 1968 , to March 26, 1968 , that (we) last saw the deceased alive on March 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Jaime Ambrad</i>	DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 3/26/68	
22d. PHYSICIAN'S NAME (Type) Jaime Ambrad, M.D.	22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/30/68	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimmek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE MAR 28 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1513
30M REV. 1968

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last Proctor Stewart Wade			2a. DATE OF DEATH Month Day Year March 25, 1968		2b. HOUR 10:50 P.	
3. SEX male		4 RACE white		5. DATE OF BIRTH Feb. 16, 1896		6 AGE (In years lost birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) construction worker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 640 Brisbane Road	
14 FATHER'S NAME Benjamin H. Wade			15. MOTHER'S MAIDEN NAME Fannie Proctor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 212-01-5399		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage, recent, etiology</u> <u>undetermined</u> <u>13 days</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>330 X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>org. undet.</u> <u>1) Bronchopneumonia, Rt. & Lt. Lower lobes, secondary to (a) above,</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 31, 1968</u> , to <u>March 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 25, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Anthony J. Young</i>		DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-26-68			
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-29-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.				25a. REC'D BY REGISTRAR DATE MAR 27 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



03871

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>residence</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>residence</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1700 Woodholme Ave.</u>		d. STREET ADDRESS <u>1700 Woodholme Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Olive</u> First <u>Blanche</u> Middle <u>Wagers</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio Bell Tele. Co.</u>	9. AGE (in years lost birthday) <u>38</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R. Wellington Wagers</u>		14. MOTHER'S MAIDEN NAME <u>J'Annette Welsh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>211-3-1147</u>	
17. INFORMANT <u>Dr. Robert R. Wagers, 1700 Woodholme Ave.</u>		Address: <u>residence</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4109</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 mins</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 6</u> , 19 <u>67</u> , to <u>Mar. 1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb. 29</u> , 19 <u>68</u> , and that death occurred at <u>6 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d. ADDRESS <u>59 Hanover Rd. Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 4, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Columbus, Ohio</u>
24. FUNERAL DIRECTOR <u>Frank H. Stencil, Pikesville 8, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MMN 8 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



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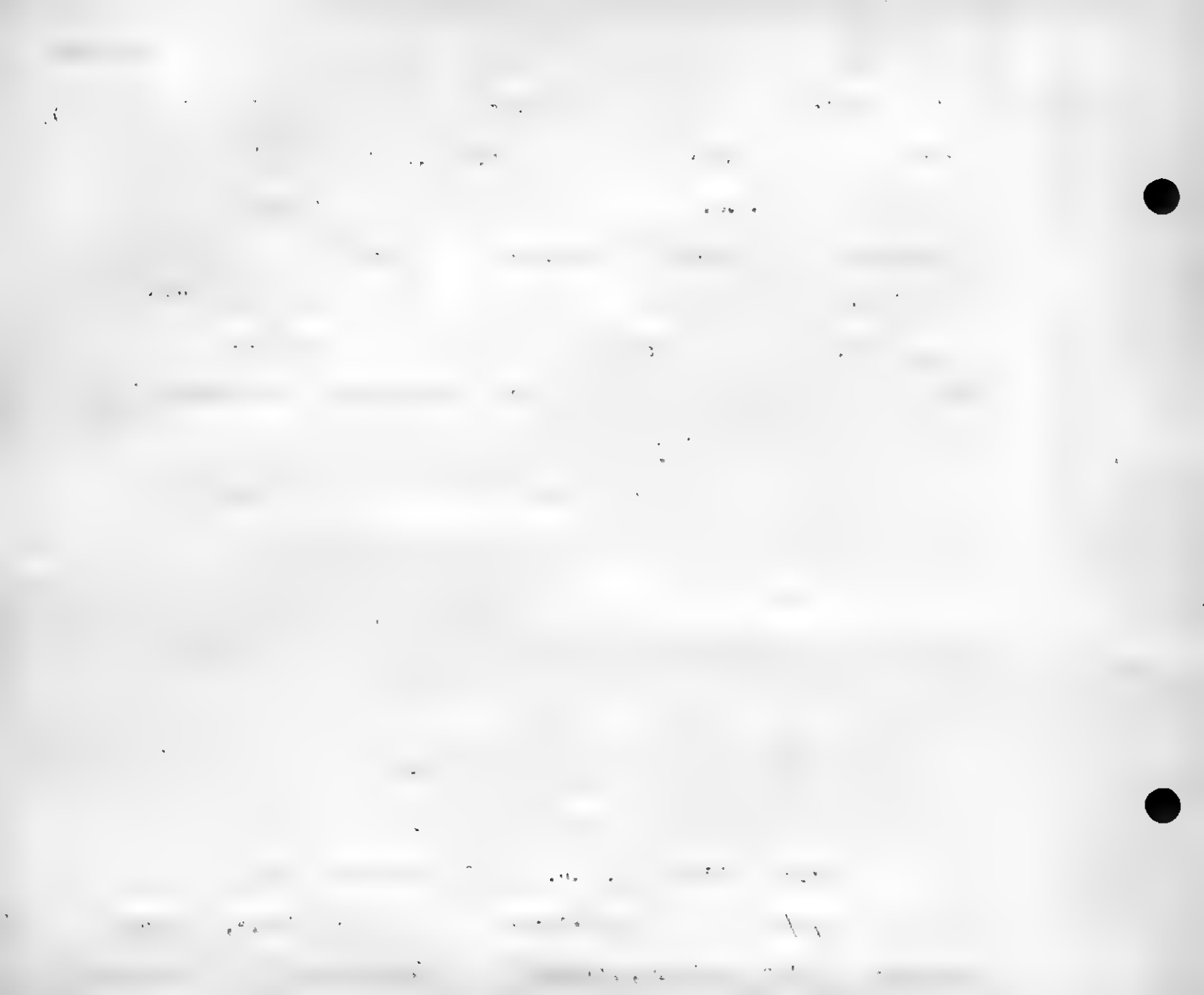
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First <u>GORDON</u> Middle <u>NO MIDDLE NAME</u> Last <u>WAGNER</u>						2a. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>68</u>			2b. HOUR <u>7:20</u> PM		
3. SEX <u>MALE</u>		4. RACE <u>Cauc.</u>		5. DATE OF BIRTH <u>8/18/1896</u>		6. AGE (In years last birthday) <u>71</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>BALTO</u>		7b. CITIZEN OF WHAT COUNTRY? <u>US</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.					
10. CITY OR TOWN OF DEATH <u>TOWSON, MARYLAND</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <u>GREATER BALTIMORE MED. (G.B.M.C.)</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RETIRED</u>			12b. KIND OF BUSINESS OR INDUSTRY <u></u> ✓		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>M.D.</u>				13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>BALTIMORE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>1137 Horners Lane, 05</u>	
14. FATHER'S NAME First <u>CHARLES H. W. WAGNER</u> Middle <u></u> Last <u></u>						15. MOTHER'S MAIDEN NAME First <u>DANIE</u> Middle <u></u> Last <u>(N.M.M.) WILKSCHLAGER</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <u>yes</u> (If yes, give branch of service) <u>WW I</u>				16b. SOCIAL SECURITY NO. <u>215-05-4066</u>		17. INFORMANT <u>MRS. RENA GARY - SAME AS PATIENT</u> Address <u></u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>											
1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1621</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>2/27</u> , 19 <u>68</u> , to <u>3/1</u> , 19 <u>68</u> , that <u>he</u> (we) last saw the deceased alive on <u>1 Mar</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death.											
22b. SIGNATURE <u>James Lawrence M.D.</u> DEGREE <u></u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>3/1/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>JAMES LAWRENCE</u>						22e. ADDRESS <u>HOSPITAL</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/4/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>			
24. FUNERAL DIRECTOR <u>Paul Neemann</u> ADDRESS <u>6667 Harford</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1968</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) Julia			First Middle Last Waitkus			2a. DATE OF DEATH Month 3 Day 1 Year 68		2b. HOUR 5:45 M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH March 6, 1883		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House In The Pines			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5 South Potomac St	
14. FATHER'S NAME John			First Middle Last Batos			15. MOTHER'S MAIDEN NAME First Middle Last Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mr Vincent Waitkus 5308 Remmell Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Discompensation 4179 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 mo. 15 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 3-24-1968 , to 3-1-1968 , that (I) (we) last saw the deceased alive on 3-28-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Wilmer K. Gallagher Sr. M.D.				22c. DEGREE M.D.		22d. ADDRESS 6209 Frederick Ave		22e. DATE SIGNED 3-1-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/4/68		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland				25a. REC'D BY REGISTRAR DATE MAR 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



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1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) CLARENCE LOVE WALKER					2a. DATE OF DEATH Month March Day 13 Year 1968		2b. HOUR 2 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH February 7, 1893		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Fort Howard		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Rubber Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY City		13c. CITY OR TOWN City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2025 Bank Street-21231	
14. FATHER'S NAME First Middle Last William Walker					15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Stewart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO WW-1 183 03 2434		17. INFORMANT Address Clinical Reds, VA Hospital, Fort Howard, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent Unknown									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CIRRHOSIS OF LIVER									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 7, 1968 to March 13, 1968 , that (I) (we) last saw the deceased alive on Mar. 13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. D. Talbert, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/14/68		
22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.					22e. ADDRESS VA Hospital, Fort Howard, Maryland				
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 3/18/68		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City or Town) (County) (State) Cuyahoga Falls Ohio			
24. FUNERAL DIRECTOR Joseph N. Zannone					ADDRESS 263 S. Conklin St		25a. REC'D BY REGISTRAR MAR 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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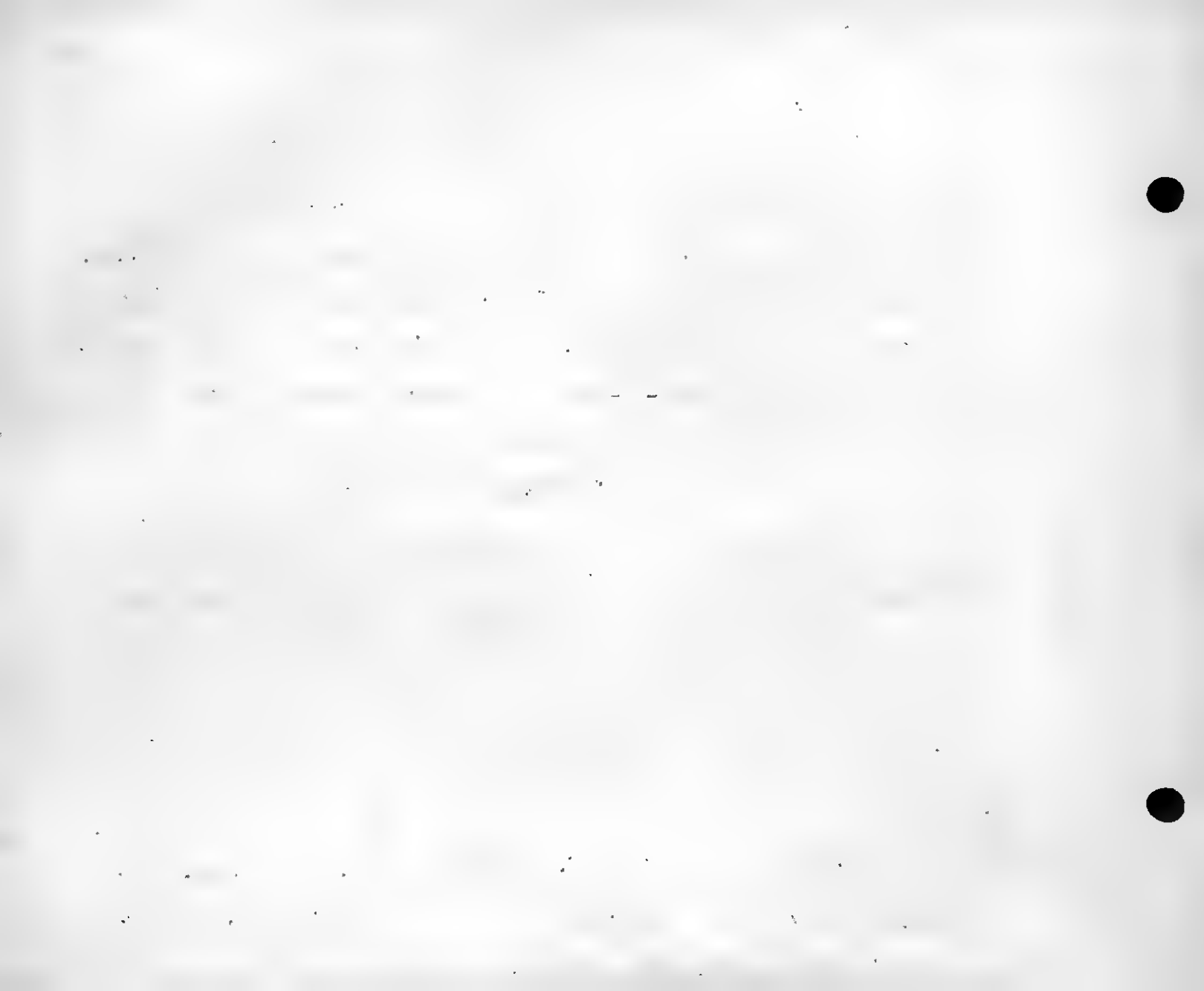
VR 1515
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03858

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
David		W		WALLACE Jr	Month	Day	Year	10:25		A. M.
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER YEAR MONTHS		7. UNDER YEAR MONTHS	
Male	White		August 4, 1922		45 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York		U.S.A.				Baltimore, Md.				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Towson		ST. JOSEPH HOSPITAL		Salesman		Auto.				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland				Baltimore				6645 Walther Ave.		
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
David		W		Wallace Sr.	Eleanor		G		Guthrie	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		099-16-7783		Mrs Eunice M Wallace		Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Massive intra-cerebral hemorrhage</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Hypertensive cardiovascular disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
440										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that NO (this hospital) attended the deceased from <u>2/29/</u> , 19 <u>68</u> , to <u>3/1/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/1/</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Lawrence F. Misanik</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>March 1, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>Lawrence F. Misanik, M.D.</u>					22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		3/2/68		Greenmount		Baltimore, Maryland				
24. FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc					Baltimore, Maryland		MAR 6 1968		<u>John A. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) CHARLES HERBERT WALPER, Jr.			2a. DATE OF DEATH March Month 26 Day 1968 Year			2b. HOUR P. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 10, 1941		6. AGE (In years last birthday) 26 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5524 Lanham Way		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shop Foreman		12b. KIND OF BUSINESS OR INDUSTRY AutoRepair			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5524 Lanham Way 21206	
14. FATHER'S NAME First Middle Last Charles Herbert Walper, Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Audrey M. Adams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. 1963-1967 218-38-3521		17. INFORMANT Address Mrs. Mary H. Walper-5524 Lanham Way				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 1729 DUE TO, OR AS A CONSEQUENCE OF Malignant Melanoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last a generalized metastasis (b) DUE TO, OR AS A CONSEQUENCE OF (c) 1 yr.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1929									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 1967 , to Mar 26, 1968 , that (I) (we) lost the deceased alive on Mar 25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George J. Richards, Jr.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/27/68			
22d. PHYSICIAN'S NAME (Type) George J. Richards, Jr.		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 30, 1968		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR H. Sander & Sons, Inc., Baltimore, Md.				ADDRESS		25a. REC'D BY REGISTRAR APR 1 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last VIOLET M WALTERS WALTERS						2a. DATE OF DEATH Month Day Year 3 22 68			2b. HOUR 4:45 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH 10-14-07			6. AGE (In years lost birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) UNKNOWN		7b. CITIZEN OF WHAT COUNTRY? UNKNOWN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.						
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTIMORE MEDICAL CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY BALTIMORE			13c. CITY OR TOWN LUTHERVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 116 WELFORD RD.		
14. FATHER'S NAME First Middle Last ROBERT HUBBS				15. MOTHER'S MAIDEN NAME First Middle Last LUCK LARNED								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) UNKNOWN		17. INFORMANT Patient's chart				Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumococcal meningitis DUE TO, OR AS A CONSEQUENCE OF (c) Possible Ruptured Brain abscess to Ventricles										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from March 19, 1968 , to March 22, 1968 , that (I) (we) lost the deceased alive on March 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE L. Baldonado						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-22-68				
22d. PHYSICIAN'S NAME (Type) LILIA C. BALDONADO						22e. ADDRESS G B M C						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-26-68		23c. NAME OF CEMETERY OR CREMATORY Babylon Rural			23d. LOCATION (City or Town) (County) (State) Babylon New York					
24. FUNERAL DIRECTOR Wm Cook-Brooks Towson						ADDRESS 1050 York Rd Towson Md		25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A13-1
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last ETI WHA PORTER WASHINGTON						2a. DATE OF DEATH Month Day Year 3 27 68			2b. HOUR 2:25 PM		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 2/22/1906		6. AGE (In years last birthday) 62 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) PA		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GREATER BALTO. MED. CENTER				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1521-15th St			
14. FATHER'S NAME First Middle Last Kass R. Truman				15. MOTHER'S MAIDEN NAME First Middle Last Willa Porter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Richard Washington - Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 175X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/6, 1968, to 3/27, 1968, that (I) (we) last saw the deceased alive on 3/27/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Adams				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/27/68					
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.				22e. ADDRESS Greater Baltimore Medical Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-1-68		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Arlington S. Phillips				ADDRESS 1720 N. Main St		25a. REC'D BY REGISTRAR APR 2 - 1968		25b. REGISTRAR'S SIGNATURE John Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

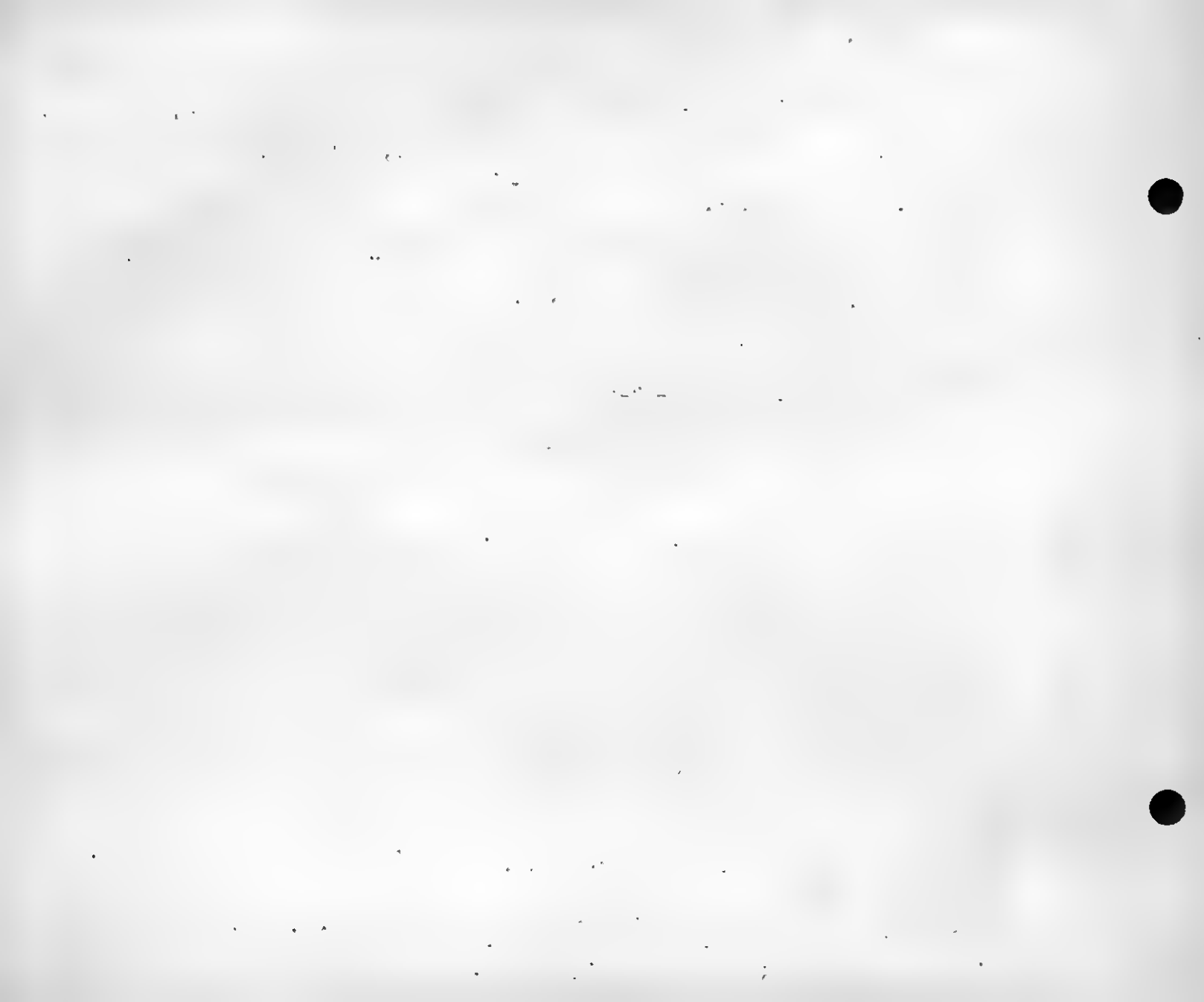
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

3879

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Frances Helen Watts			2a. DATE OF DEATH Month March Day 8 Year 1968			2b. HOUR 12:45 p.			
3. SEX female		4. RACE white		5. DATE OF BIRTH March 10, 1901		6. AGE (in years last birthday) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. INS OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2019 Frederick Ave.		
14. FATHER'S NAME First Nelson Middle Duchesney Last			15. MOTHER'S MAIDEN NAME First Catherine Middle Pennington Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 215-22-1007		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 7 , 19 66 , to March 8 , 19 68 , that (I) (we) last saw the deceased alive on March 8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (direct) view the body after death.									
22b. SIGNATURE Diomidis L. Pirovolidis, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED 3-8-68				
22d. PHYSICIAN'S NAME (Type) Diomidis L. Pirovolidis, M.D.					22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-12-68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL BALTIMORE		23d. LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR George L. Schwab ADDRESS 1404 E. ...					25a. REC'D BY REGISTRAR DATE MAR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First EUGENE	Middle A.	Last WEEDEN	2a. DATE OF DEATH Month 3 Day 26 Year 68		2b. HOUR 3:00AM	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 9/21/93		6. AGE (In years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		Md.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY REFINING CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 430 ARCHER STREET	
14. FATHER'S NAME First JOHN Middle WEEDEN			15. MOTHER'S MAIDEN NAME First ABRELLA Middle JONES Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (If yes give year or dates of service) WW I		16b. SOCIAL SECURITY NO. 216 12 82 12		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS FAR ADVANCED, BILATERAL 011.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I (this hospital) attended the deceased from 2/23/68 , 19____, to 3/26/68 , 19____, that I (we) last saw the deceased alive on 3/26/68 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above I (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. D. Talbert, M.D.				DEGREE PHYS.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/26/68	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR Irving P. Carroll		ADDRESS 1712 W. North Ave Baltimore, Md.		25a. REC'D BY REG STRAR DATE 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Alfred			First Middle Last			2a DATE OF DEATH Month March Day 5 Year 1968			2b HOUR 1:15AM		
3. SEX Male			4 RACE White			5. DATE OF BIRTH February 8, 1882			6. AGE (In years last birthday) 86 YRS.		
7a. BIRTHPLACE (State or foreign country) Germany			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Barber			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before adgession) - STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 2909 Willoughby Rd.			14 FATHER'S NAME First Middle Last Unknown			15 MOTHER'S MAIDEN NAME First Middle Last Louise Kitzig					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-22-4222			17. INFORMANT Mrs. Julia A. Wenke			Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/23/ , 19 68 , to 3/5/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/5/ , 19 68 and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Victoria Escobar</i>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED March 5, 1968		
22d. PHYSICIAN'S NAME (Type) Victoria Escobar, M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REBURY (Specify)			23b. DATE 3/8/68.			23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS			25a. REC'D BY REGISTRAR MAR 6 1968			25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

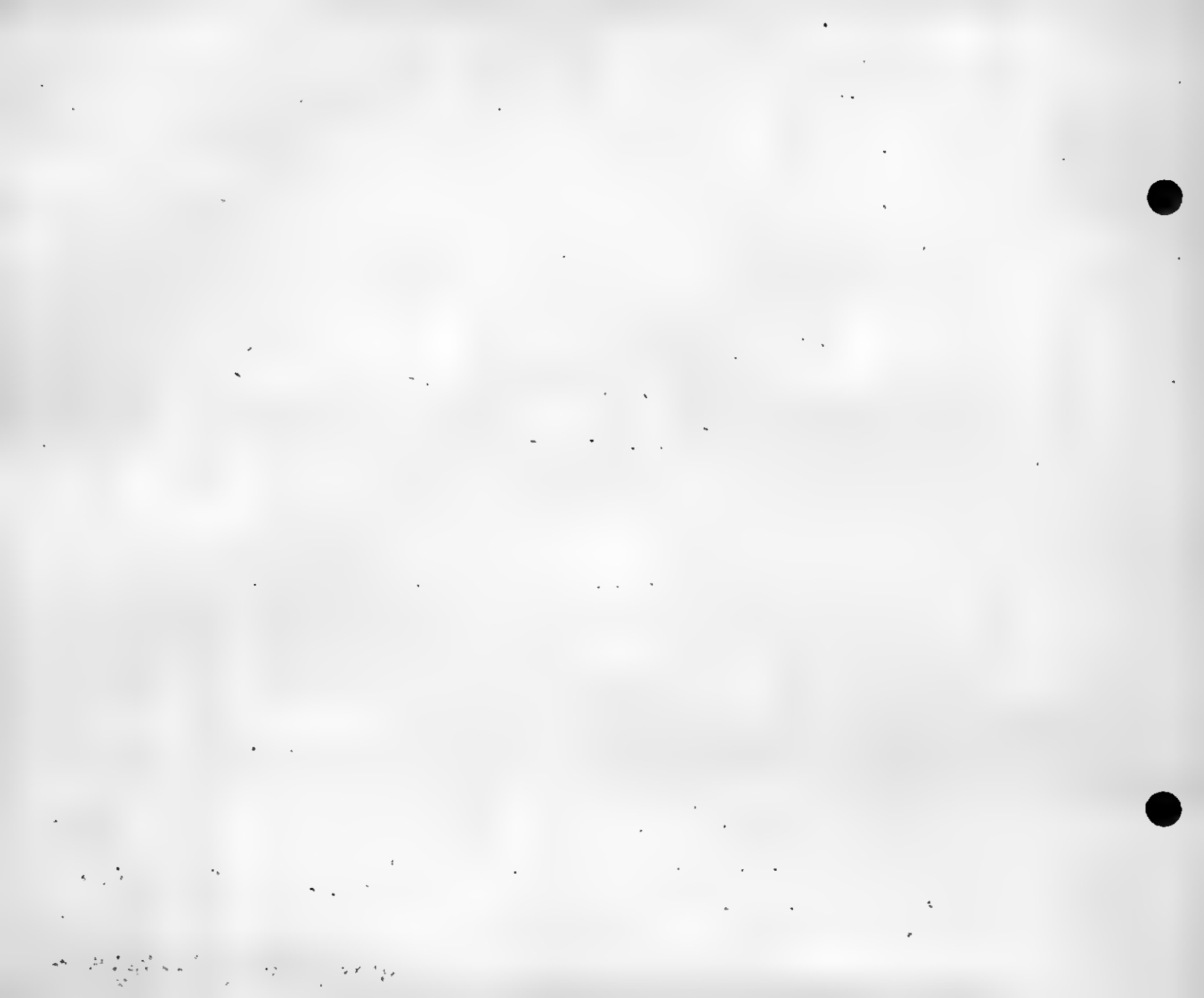
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Pearl Dudley Wessel</u>			2a. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1968</u>			2b. HOUR <u>5:25</u> PM					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>4/19/14</u>		6. AGE (in years last birthday) <u>53</u> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.					
10. CITY OR TOWN OF DEATH <u>Owings Mills, Md.</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Rosewood State Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>None</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Queen Anne's</u>			13c. CITY OR TOWN <u>Church Hill</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Church Hill, Md</u>	
14. FATHER'S NAME First <u>William Henry</u> Middle <u>Wessel</u> Last <u>Wessel</u>			15. MOTHER'S MAIDEN NAME First <u>Lena</u> Middle <u>Stoey</u> Last <u>Wessel</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Rosewood Records</u> Address <u>Owings Mills, Md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>517X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bronchiectasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 days</u> <u>15 years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1) Congenital Albinism 2) Severe mental retardation</u>											
19a. DATE OF OPERATION _____			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)			21b. TIME OF INJURY Hour <u>_____</u> A.M. Month <u>_____</u> Day <u>_____</u> Year <u>19</u> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) _____					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) _____			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>30</u> , to <u>March 23</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>March 23</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>D. Crosby Greene, M.D.</u> DEGREE _____						ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3/23/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>D. CROSBY GREENE, M.D.</u>						22e. ADDRESS <u>Rosewood State Hospital</u> <u>Owings Mills, Md. 21117</u>					
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>3-25-68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>			23d. LOCATION (City or Town), (County) (State) <u>Church Hill</u> <u>Md</u>		
24. FUNERAL DIRECTOR <u>Edward Lane Church Hill 4/12/68</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 29 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Frank J. Judge</u>		



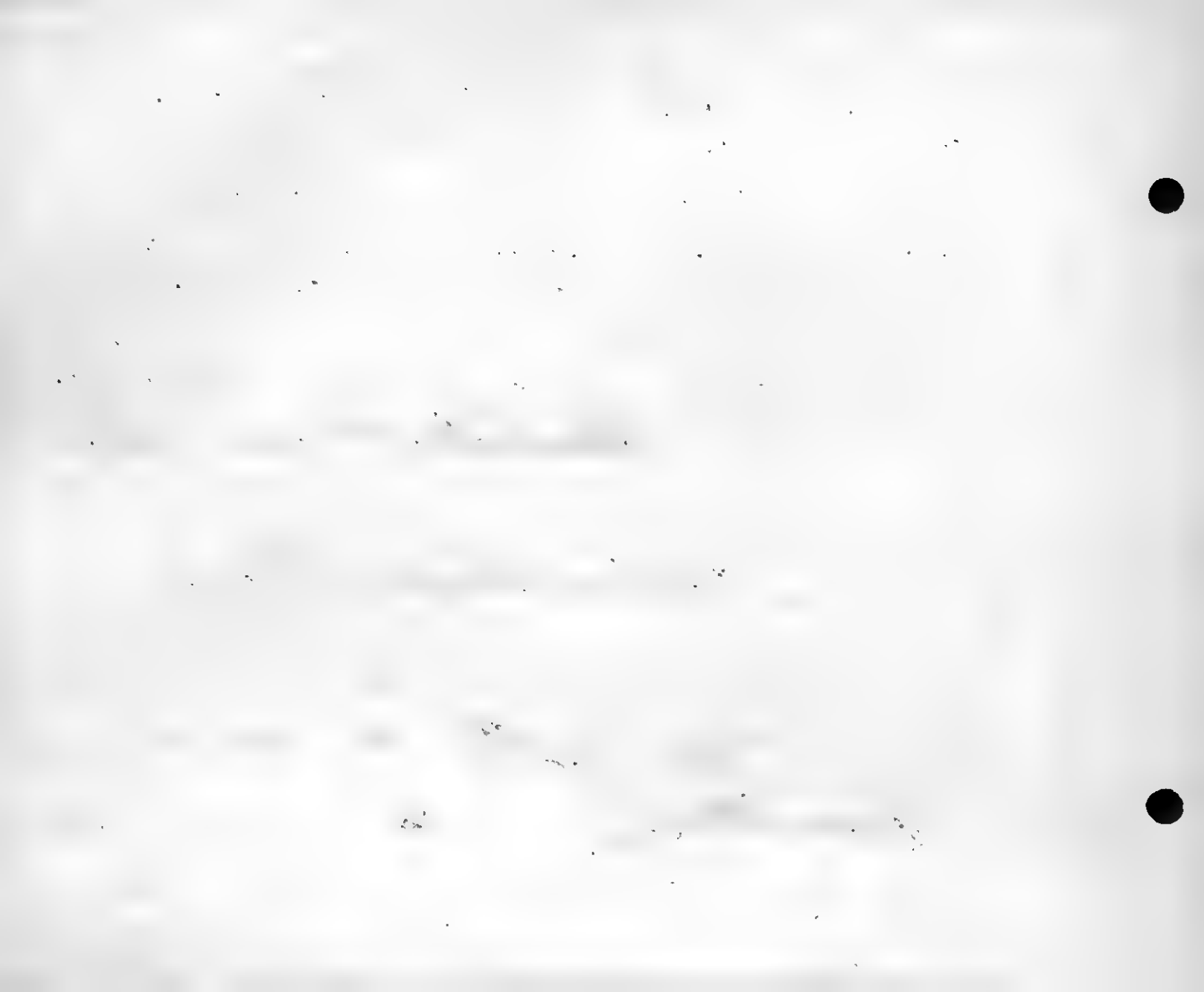
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) AIDA JOSHINE WHITE			2a DATE OF DEATH MARCH Month 3 Day 4 Year 68			2b HOUR M			
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH SEPT. 13 1911		6 AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH CATONSVILLE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 322 GREENLOW RD.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALES		12b KIND OF BUSINESS OR INDUSTRY DEPT STORE			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b COUNTY BALTO.		13c CITY OR TOWN CATONSVILLE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 322 GREENLOW RD	
14 FATHER'S NAME First THOMAS Middle BARRETT Last AGNES			15 MOTHER'S MAIDEN NAME First AGNES Middle I Last FLORIO						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address Mrs. Carl Horn - 322 GREENLOW RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephrotic Heart Disease 378 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 410 Nephrosclerosis & arteriosclerosis									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1960 to 3-4-68 , that (I) (we) last saw the deceased alive on 3-4-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hilary M. J.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-5-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/7/68		23c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery		23d. LOCATION (City or Town) (County) (State) CLARKSVILLE MD.			
24 FUNERAL DIRECTOR Farley - CAULFIELD		ADDRESS CATONSVILLE MD.		25a REC'D BY REGISTRAR DATE MAR 8 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Francis E. Wible</u>			2a. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>68</u>		2b. HOUR <u>12:45 PM</u>
3. SEX <u>Male</u>	4. RACE <u>Cau.</u>	5. DATE OF BIRTH <u>1-28-1900</u>		6. AGE (In years last birthday) <u>68</u> YRS	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <u>Hollywood, Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Greater Balt. med. Center</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired Draftsman</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Balto.</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>2616 Hillcrest Ave.</u>
14. FATHER'S NAME First Middle Last <u>Joseph - Wible</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Martha - Wible</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>212-05-4479</u>	17. INFORMANT <u>Mrs. Madelyn Wible</u>		Address <u>Same</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>2029</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>probable malignant lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>2002 ASCVD with old cerebral infarct</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <u>68</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> , 19 <u>68</u> , to <u>3/23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. Breiteneker</u>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/23/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Leonard Ruck</u>		22e. ADDRESS <u>Ine Baltimore, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/26/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		23e. REC'D BY REGISTRAR DATE <u>MAR 26 1968</u>			
23f. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>					

1990

1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the back of the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05885

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b. HOUR	
Charles		Arthur	WILKERSON		Month Day Year March 26, 1968		10:05 M	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	F UNDER 1 YEAR		F UNDER 24 HRS.
Male	White		September 14, 1888		79 YRS	MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland	U.S.A.				Baltimore,		Md	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		ST. JOSEPH HOSPITAL		Steamfitter		Riggs-Distler		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER			
Maryland		Baltimore	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4304 Kenwood Ave.			
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last					
Alexander Wilkerson			Stover					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT Address				
No		212-07-2438		Frances V. Wilkerson- 4304 Kenwood Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Carcinoma of lung, bilateral.								
162.1 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
10.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (this hospital) attended the deceased from 3/24/1968, to 3/26/1968, that (I (we) last saw the deceased alive on 3/26/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Reynaldo Orjuela-Gomez, M.D.				6720 York Rd., Towson, Md. 21204		March 26, 1968		
22d. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
		Burial		3-30-68		Gardens of Faith Cemetery Balto. Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John C. Miller Inc-415 Belair Road-21206				DATE		MAR 29 1968		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form. PMS may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR				
Elizabeth Cooper Williams						March 2 1968			10:54 PM				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR				
F	W	3/30/89		78 YRS			March 2 1968		12:00 PM				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Ky.			USA.						Baltimore Md				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville				15 Ingleside Ave.				Retired					
13a. USUAL RESIDENCE (Where deceased lived, if not last residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md				Balto		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15 Ingleside Ave.			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S M maiden name			First Middle Last				
Charles Cooper						Amy Hyatt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS							
No				202-09-2829		Family Recorded Bible							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Vascular Disease											Sudden		
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4221													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			James M. Frederick M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			James M. Frederick M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3/2/68				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			1311 Francis Ave				
						ADDRESS (Street, city, town, or county)			Balto, Md. 21227				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		3-4-68		St John		Ellicott City							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Higinbotham-Slack						MAR 1 1968							

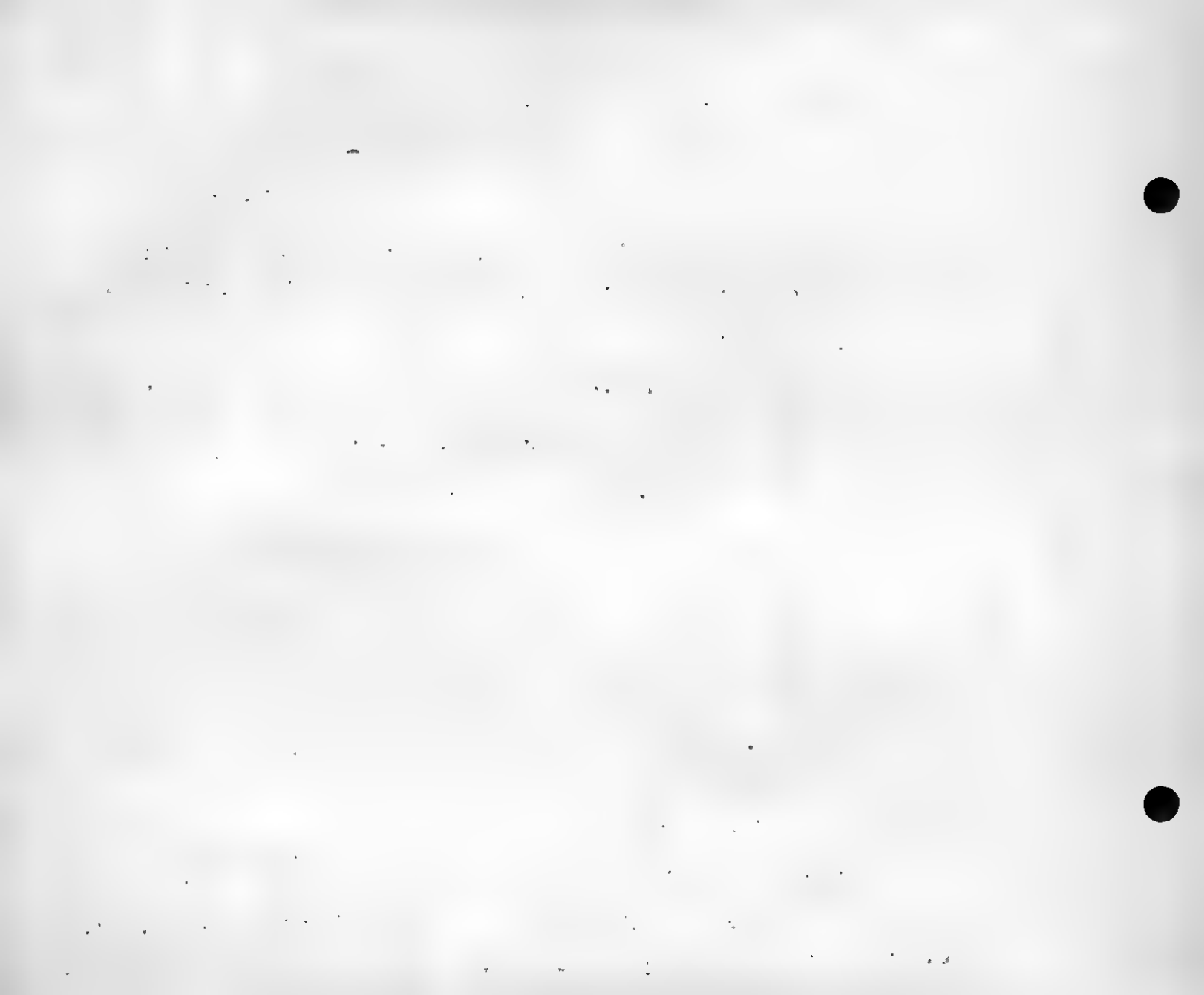
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Carl Erich Wolf			2a. DATE OF DEATH March Month 17 Day 1968			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 22. 1888		6. AGE (In years last birthday) 79 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Lexington Mkt			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Baltimore		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2200 Mosby Ave.	
14. FATHER'S NAME First Emil Middle Wolf Last			15. MOTHER'S MAIDEN NAME First ? Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give year or dates of service)		16b. SOCIAL SECURITY NO 215.01.9981		17. INFORMANT Julia Wolf		Address 2200 Mosby Ave. 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 424 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-9-1968 , to 3-17-1968 , that (I) (we) last saw the deceased alive on 3-15-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wilmer K. Gallager, MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-18-68	
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallager				22e. ADDRESS 6209 Frederick Ave Balto. 25 Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Md			
24. FUNERAL DIRECTOR J.T. Stansbury				ADDRESS 6411 Windsor Mill Rd.		25a. REC'D BY REGISTRAR MAR 19 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

038883

03873

1. DECEASED-NAME (Type or print) First Middle Last <i>Ruth Marie Wood</i>			2a. DATE OF DEATH Month <i>MARCH</i> Day <i>27</i> Year <i>1968</i>		2b. HOUR <i>4 P. M.</i>
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>August 13, 1895</i>		6. AGE (In years last birthday) <i>72</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Mississippi</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE</i> Md.
10. CITY OR TOWN OF DEATH <i>CATONSVILLE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>House in the Pines 16 Rusting Ave</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>2240 McHENRY ST.</i>
14. FATHER'S NAME First Middle Last <i>Unknown Willis</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-10-3687</i>		17. INFORMANT Address <i>JAMES R. WOOD 2240 McHENRY ST.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Lung</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>62-8</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>163X</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-2-</i> , 19 <i>68</i> , to <i>3-28-</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3-28-</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <i>Wilmer K. Gallagher M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>3-28-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, M.D.</i>				22e. ADDRESS <i>6209 Frederick Rd., Balt. Md. 21228</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>3-30-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CEDEAR HILL</i>		23d. LOCATION (City or Town) (County) (State) <i>Brooklyn Anne Arundel Md</i>	
24. FUNERAL DIRECTOR <i>Francis W. Disher 2101 Rudwick Ave.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				DATE <i>MAR 29 1968</i>	

$\frac{d}{dt} \left(\frac{1}{r^2} \right) = -\frac{2}{r^3} \frac{dr}{dt}$

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
EDWARD				ZAKROCZYNSKI				<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 3/4/68 19	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD
MALE	WHITE	12/29/14		53 YRS.					Month 3/4/68 Year 19 2d. HOUR 1:15P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD		VET ADM HOSPITAL				BAKER		BAKERY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		BALTIMORE				521 S. Wolfe Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Frank Zakroczyński			First Middle Last Alexandria Barczykowski						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes WW II			218 07 35 87		CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMATOMA 887X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 903.0 LAENNEC'S CIRRHOSIS									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
2/26/68			SUBDURAL HEMATOMA				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		2/19/68 P.M.		FELL IN BATHTUB AND STRUCK HEAD					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
		HOME		521 S. Wolfe Street, Baltimore, Md. 21231					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3/4/68	
EXAMINER'S NAME (Type)		MELVIN B. DAVIS, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
		6800 MORNINGTON ROAD, BALTIMORE, MD. 21222							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/8/68		BALTIMORE NATIONAL		BALTIMORE, MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
T. Fishus		Fisher/Ozazewski Funeral Home		DATE MAR 7 1968		Charles Judge			
		1930 Eastern Ave. Baltimore, Md.							

STOLE



SECRET

TOP SECRET

CONFIDENTIAL

2/8/68

SECRET

CONFIDENTIAL